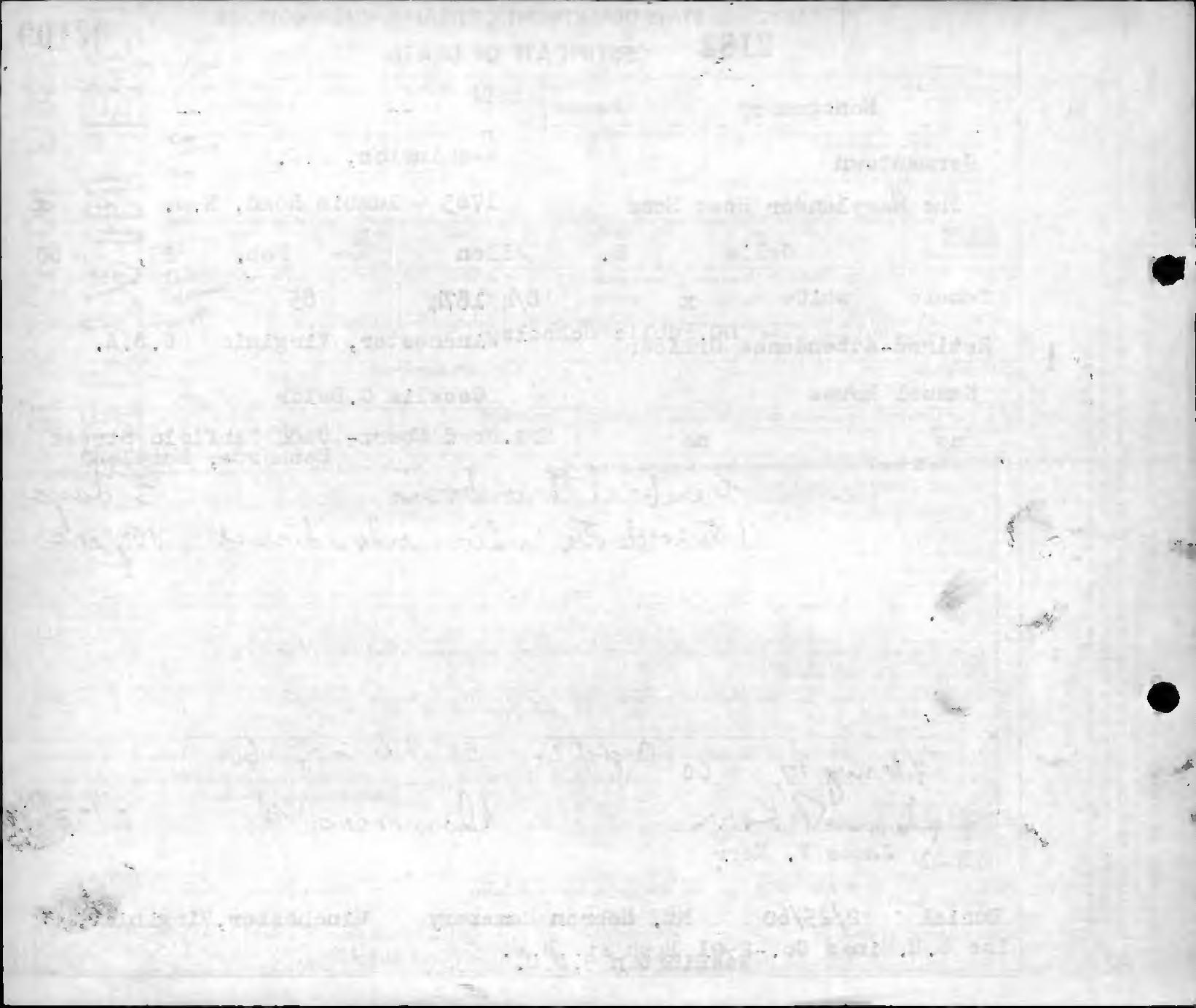


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2182 CERTIFICATE OF DEATH

Reg. Dist. No.

02103

| | | | | | | | | |
|---|-------------------------------------|---|--|---|---|---|----------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home | | d. STREET ADDRESS 1763 Columbia Road, N.W. | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Gelia | Middle B. | Last Allen | | | | | |
| 4. DATE OF DEATH Feb. 23, 1960 | Month | Day | Year | | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/4/1874 | 9. AGE (In years from birthday) 85 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Attendance Officer | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (State or foreign country) Winchester, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Samuel House | | 14. MOTHER'S MAIDEN NAME Cecelia C. Belts | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | INFORMANT Mrs. Fred Eberz | Address 8604 Garfield Street Bethesda, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Cerebral thrombosis DUE TO (c) Arteriosclerotic cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. | | 20f. (City or town) Damascus, Md. | (County) Damascus, Md. | (State) Md. |
| 21. I certify that I attended the deceased from August 16, 1959 to Feb. 23, 1960 that I last saw the deceased alive on February 17, 1960 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, City or Town, state) Damascus, Md. | | | | | | | | |
| ACTUAL SIGNATURE <i>James P. Kerr</i> | DATE SIGNED 2/23/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) James P. Kerr | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/25/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hebron Cemetery | | 22d. LOCATION (City, town, or county) Winchester, Virginia | | (State) Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington, D.C. | | ADDRESS 14th St. N.W. Washington, D.C. | 24a. REC'D BY REGISTRAR DATE FEB 24 1960 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kerr | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2183 CERTIFICATE OF DEATH

02110

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) Bethesda | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia | |
| | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 5510 First Street, N.W. | | | |
| 3. NAME OF DECEASED (Type or print) Bernard | | First | Middle | Last | 4. DATE OF DEATH February 17 |
| | | | Wilson | Anthony, Jr. | Month Year Day 1960 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH November 27, 1959 | 9. AGE (In years last birthday) yrs. 2 Months 20 Days 0 Hours 0 Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 13. FATHER'S NAME Bernard W. Anthony | | 14. MOTHER'S MAIDEN NAME Gloria Herron | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia | | | | | |
| 769.3 DUE TO | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congenital Toxoplasmosis | | | | | |
| DUE TO | | | | | |
| (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 19 | | | | | |
| 21. I certify that I attended the deceased from January 12, 1960 , to February 17, 1960 , that I last saw the deceased alive on February 17, 1960 , and that death occurred at 7:50 a.m. from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-17-60 | | | | | |
| ACTUAL SIGNATURE Howard M. Kravitz | | | | | |
| PHYSICIAN'S NAME (Type) HOWARD M. KRAVITZ, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 2/20/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL FACILITY Bethesda Cemetery | |
| Burial | | 2/20/60 | | Bethesda Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Adam Funeral Home | | ADDRESS 4748 - Wisconsin | | 24a. REG'D BY REGISTRAR FEB 23 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 2 days after death.

VS. A15M
5M 7/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10311

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| FOR STATE HEALTH DEPT. | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | | | | | | | |
| a. COUNTY | | b. STATE | | | | | | | |
| Montgomery | | Md | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | | | | | | |
| Silver Spring | | 4 yrs | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | d. STREET ADDRESS | | | | | | | |
| 3971 Wendy Lane | | 3971 Wendy Lane | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | |
| William Edward Atkinson | | | | | | | | Feb 28 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. | |
| Male | | white | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10-11-1890 | | 69 yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Casuit Sup. Building Co. | | | | Maryland | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| Charles Atkinson | | Elizabeth Ellis | | (If yes, give name and date of service) | | Margaret Atkinson (wife) Then 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH sudden | | | |
| 420.1 | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| MEDICAL CERTIFICATION | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) <u>2-28-60</u> | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/2/60</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington Mall</u> | | 22d. LOCATION (City, town, or county) <u>Bel Air</u> (State) <u>Md</u> | | | |
| 23. FUNERAL DIRECTOR <u>Frank J. Broschart</u> | | ADDRESS <u>5732</u> | | 24a. REC'D BY REGISTRAR <u>Mar 3 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finegan</u> | | | |
| VS. A15ME SM 7/59 | | | | DATE | | | | | |

RECORDED IN THE OFFICE OF THE CLERK OF THE
CITY OF NEW YORK, APRIL 22, 1968, BY JAMES M. HARRIS

CLERK

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

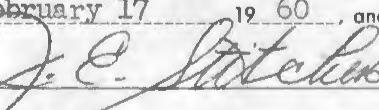
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

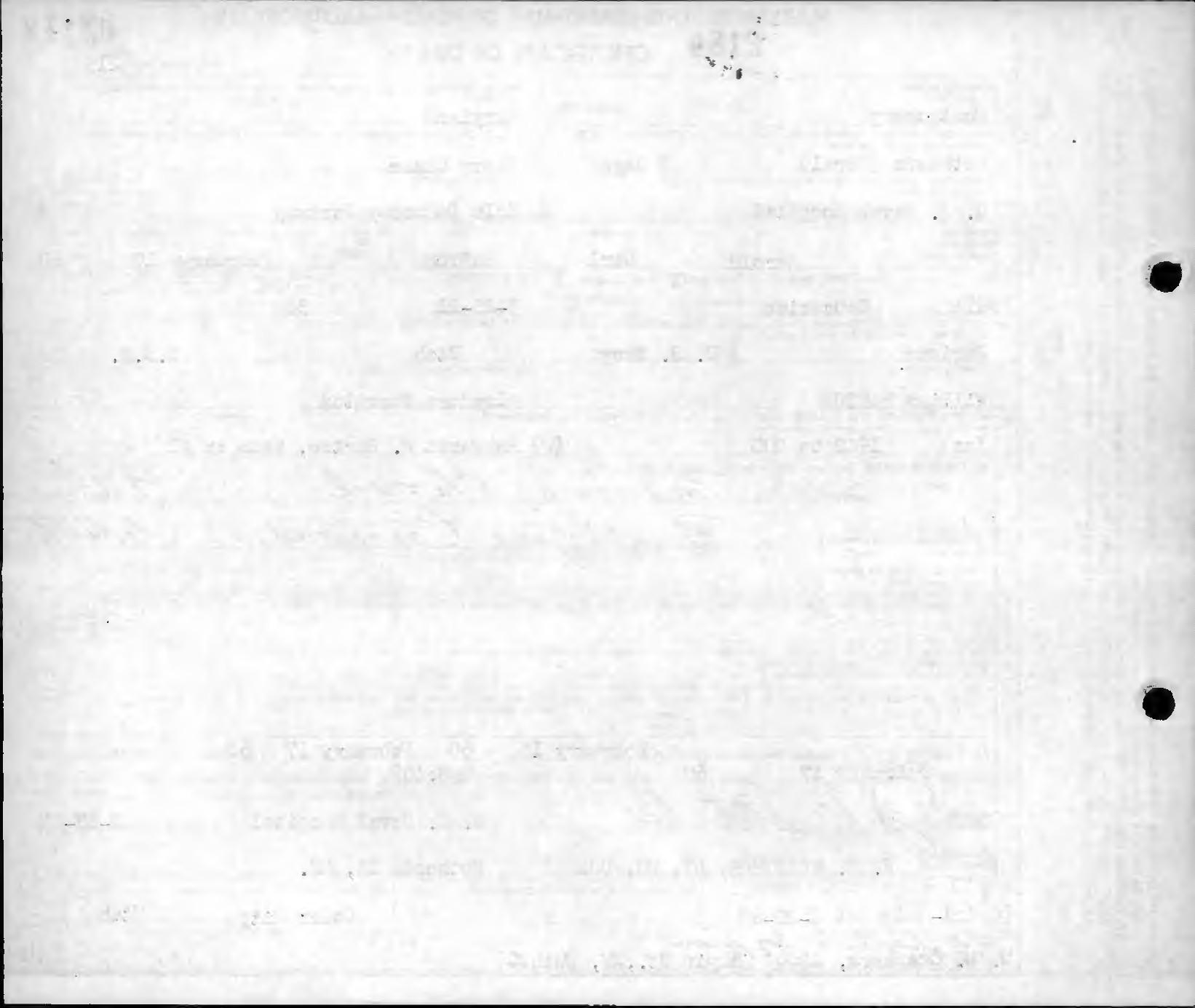
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2184 CERTIFICATE OF DEATH

Reg. Dist. No. 215

02112

| | | | | | | | | | |
|--|--------------------------------------|---|--|--|---|---|--|------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. STREET ADDRESS 58 Chevy Chase | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 2 days | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Harold | | First | Middle | Last | 4. DATE OF DEATH BARTON | Month | Day | Year | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-25-21 | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | | 11. BIRTHPLACE (State or foreign country) Utah | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William BARTON | | 14. MOTHER'S MAIDEN NAME Isadore Thornton | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1940 to DOD | | INFORMANT (W) Margaret M. Barton, same as #2 | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 | | DUE TO Pneumonia, bila tekal | | INTERVAL BETWEEN ONSET AND DEATH 7 days | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) | | DUE TO Bronchogenic Carcinoma | | Duration 6 months | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Baltimore | | (County) Baltimore | (State) Md. |
| 21. I certify that I attended the deceased from February 15, 1960 to February 17, 1960 that I last saw the deceased alive on February 17, 1960 , and that death occurred at 8:40P.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED 2-18-60 | | | |
| ACTUAL SIGNATURE  | | | | M.D. U. S. Naval Hospital | | | | | |
| PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN | | Bethesda 14, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | | 22b. DATE THEREOF 2-20-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL W. W. Chambers, 1400 Chapin St., NW, WashDC | | 22d. LOCATION (City, town, or county) Cedar City | | (State) Utah | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers by son</i> | | ADDRESS W. W. Chambers, 1400 Chapin St., NW, WashDC | | 24a. REC'D BY REGISTRAR FEB 23 '60 | | 24b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02113

2185

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|---|---|---|---|--|
| 1. | | PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | |
| | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 6 days | | | |
| | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington | | | |
| | | | | d. STREET ADDRESS 3219 Decatur Ave | | | |
| 3. NAME OF DECEASED (Type or print) | | First Ruth | Middle Elizabeth | Last Belt | 4. DATE OF DEATH Feb 11 Year 1960 | | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 12/24/1924 01 | 9. AGE (In years last birthday) 58 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME David B GOTIWALS | | GOTIWALS | | 14. MOTHER'S MAIDEN NAME Edith Hunt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT Husband Mr. Alvin | M. BELT Address Same as Above. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | Congestive heart failure Myocardial hypertension | | INTERVAL BETWEEN ONSET AND DEATH 7 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic cystic hydronephrosis + ch. pyelonephritis | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 105-15 Summit Ave | (County) (State) Kensington, MD | | |
| 21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>60</u> , to <u>11 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10 Feb</u> , 19 <u>60</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE Horace Bernton M.D. | | ADDRESS (Street, city or town, state) 105-15 Summit Ave 11 Feb Kensington, MD | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/13/60 | 22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. Raymond L. Jester | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR FEB 15 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135 CERTIFICATE OF DEATH

Reg. Dist. No.

02114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|------------------|---|---|---|------------------|---|---------------------|---------------------|
| 1. PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE | | MARYLAND b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | 30½ Ave | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Montgomery Silver Spring | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Washington San & Hospital Washington | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| FANNIE | | BINDES | | BERMAN | February | 7 | 19 | 60 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS |
| F | W | | | 40-14-84 | | 75 yrs. | Months Days | Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Housewife | | — | | Poland | | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Samuel Dykstein | | — | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | (Atc) Address | | |
| | | — | | Mrs. Jack Ager | | 1001 Raymond St. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Pulmonary Embolus... INTERVAL BETWEEN ONSET AND DEATH 260X DUE TO 3rd floors | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Generalized arteriosclerosis | | | | | | |
| (b) | | Diabetes Mellitus | | | | | | |
| DUE TO | | 7 years | | | | | | |
| (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from January 1, 1960, to February 7, 1960, that I last saw the deceased alive on February 7, 1960, and that death occurred at 11:20 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) M.D. 9210 Colesville Rd., Silver Spring, Md. DATE SIGNED 2/8/60 | | | | | | |
| ACTUAL SIGNATURE: Sydney Leventhal, M. D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | 9210 Colesville Road, Silver Spring, Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-9-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Beth Shalom Cemetery | | 22d. LOCATION (City, town, or county) Washington, D.C. (State) | | |
| 23. FUNERAL-DIRECTOR'S SIGNATURE | | ADDRESS B. Lengansky & Sons 3501-14 St. 11 W. | | | | | | |
| | | 24a. REC'D BY REGISTRAR DATE FEB 10 '60 | | | | | | |
| | | 24b. REGISTRAR'S SIGNATURE Collins S. Trahan | | | | | | |



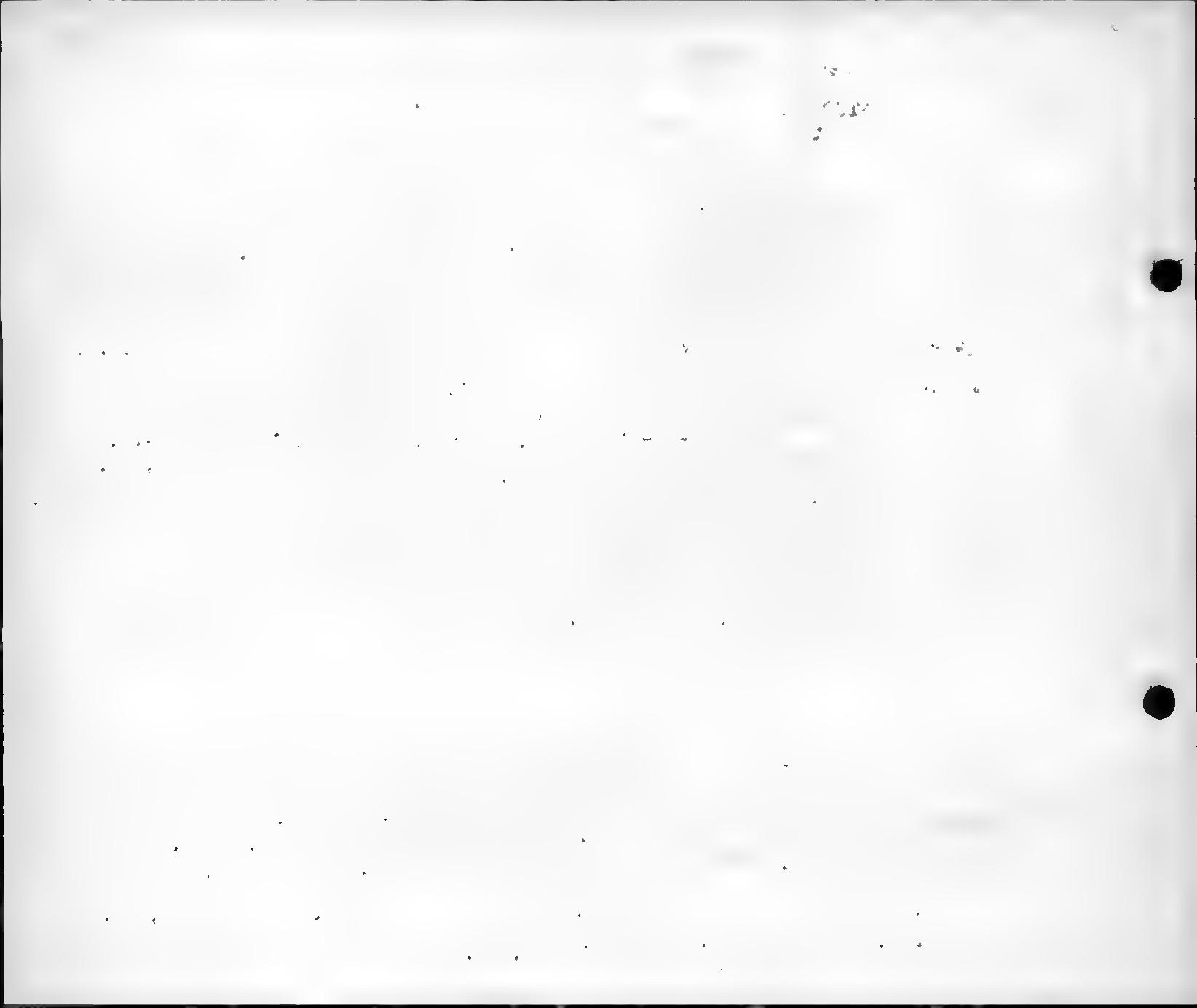
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02115

2117 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|---|---|--|--|----------------------|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | c LENGTH OF STAY IN 1b 1 month | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | d STREET ADDRESS 14403 COLFAX STREET | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2221 LUZERNE AVENUE | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) BELMA | First BELMA | Middle BLANCHARD | Last BLANCHARD | | |
| 4. DATE OF DEATH FEB. 6 1960 | Month FEB. | Day 6 | Year 1960 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/27/05 | | |
| 9. AGE (In years last birthday) 54 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME MILTON SMITH | 14. MOTHER'S MAIDEN NAME SARA DANIELS | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. 237-14-1394 | INFORMANT Mrs. James L. Cambas, 2221 Luzerne Ave. | Address Silver Spring, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | |
| <i>Coronary Occlusion</i> | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteoarthritis | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred while at work | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At work | 20f. (City or town) 21159 | (County) 16626 | (State) MD |
| 21. I certify that I attended the deceased from 2/1/59 , 19, to 2/6/59 , 19, that I last saw the deceased alive on 2/6/59 , 19, and that death occurred at 6 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16626 Georgia Ave 21159 Silver Spring, Md. | | | | | |
| ACTUAL SIGNATURE John J. CURRY | | | | | |
| PHYSICIAN'S NAME (Type) JOHN J. CURRY | | DATE SIGNED 2/6/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/9/60 | 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. PUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR FEB. 9 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2186

CERTIFICATE OF DEATH

Reg. Dist. No.

02118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>13 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5901 Lone Oak Drive</i> | | e. STREET ADDRESS <i>15901 Lone Oak Drive</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Rolland E. Blosser</i> | | First <i>E.</i> | Middle <i>.</i> |
| 4. DATE OF DEATH <i>February 16 1960</i> | Month <i>February</i> | Day <i>16</i> | Year <i>1960</i> |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 22, 1887</i> |
| 9. AGE (In years last birthday) <i>72 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS Days <i>0</i> | 12. IF UNDER 24 HRS Hours <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mining Engineer</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Newcom Standard</i> | 11. BIRTHPLACE (State or foreign country) <i>Tennessee</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> |
| 13. FATHER'S NAME <i>Isiah Blosser</i> | 14. MOTHER'S MAIDEN NAME <i>Martha Whitcraft</i> | Address <i>Bethesda, Md</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | 16. SOCIAL SECURITY NO. <i>WW#1</i> | INFORMANT <i>Josephine Blosser-5901 Lone Oak Drive</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial anoxia</i> DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>anemia from inanition</i> DUE TO (c) <i>Carcinoma Stomach & metastases</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>27 hrs</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Nov. 1959</i> , to <i>Feb. 16, 1960</i> , that I last saw the deceased alive on <i>Feb. 15, 1960</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Margaret E. Callan</i> | | M.D. | <i>1700 Bradley Blvd. Chevy Chase, Maryland</i> |
| PHYSICIAN'S NAME (Type) <i>Margaret E. Callan, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2/19/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. 2901 14th St. N.W.</i> | | ADDRESS | 24a. REC'D BY REGISTRAR DATE <i>FEB 18 '60</i> |
| | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2187

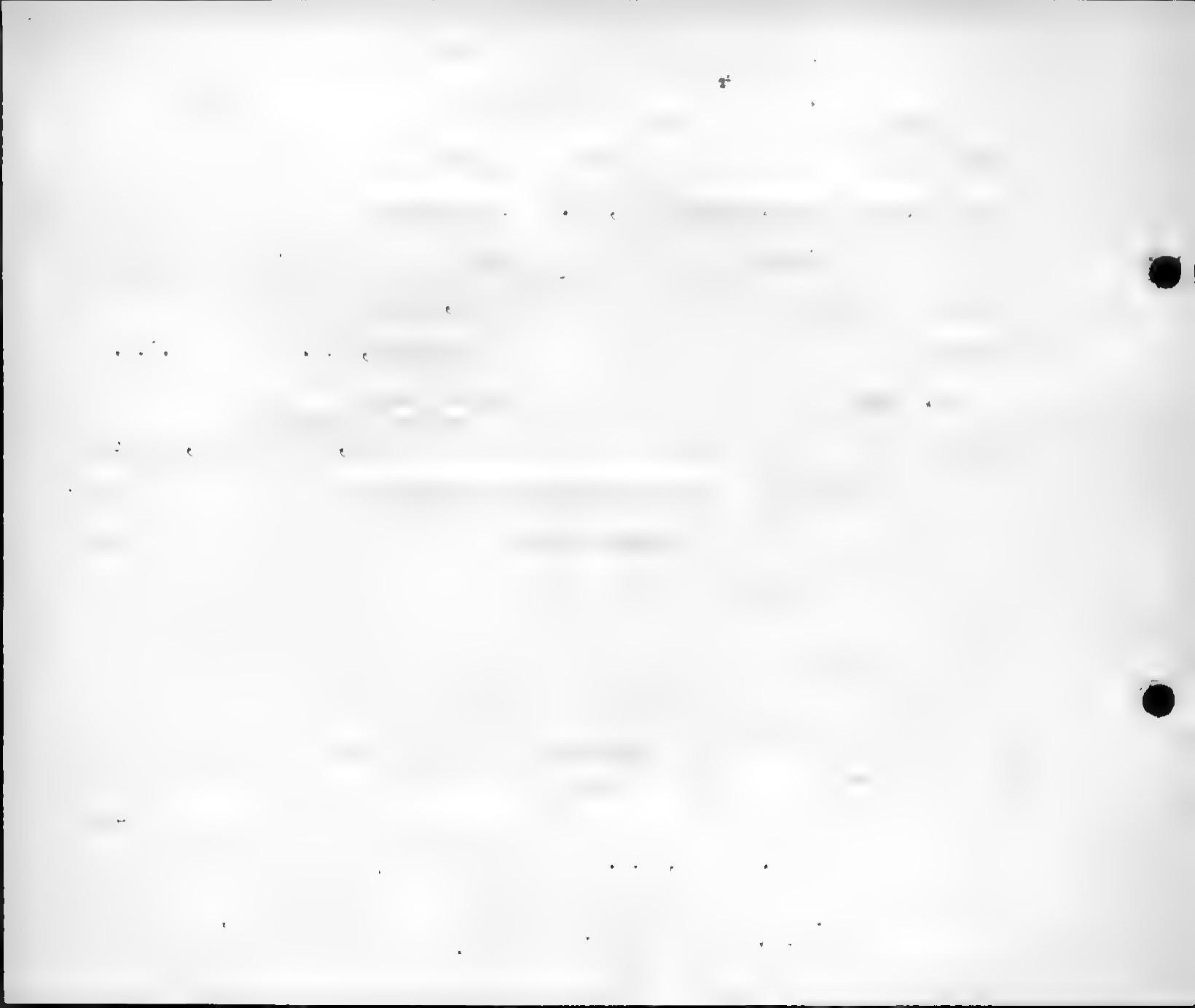
CERTIFICATE OF DEATH

Reg. Dist. No.

02117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|----------------------------------|---|--|--|--|--|--------------------------------------|-------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) d. STATE Maryland | | b. COUNTY Prince Georges | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 51 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 2 D Gardenway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NO | | |
| 3. NAME OF DECEASED (Type or print) Michael | | First Michael | Middle Dix | Last Boone | 4. DATE OF DEATH February | Month 8 | Day 19 | Year 60 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1948 | 9. AGE (In years last birthday) 11 yr. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Hours 0 | Min. 0 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 10c. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Dix C. Boone | | 14. MOTHER'S MAIDEN NAME Helen Crowley | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 196.9 | | DUE TO (b) Osteogenic Sarcoma | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | DUE TO (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from December 19, 1959 to February 8, 1960 , that I last saw the deceased alive on February 8, 1960 , and that death occurred at 12:10 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) Arthur S. Thomas | | | | |
| ACTUAL SIGNATURE Charles E. Mengel, M.D. | | | | DATE SIGNED 2-8-60 | | | | |
| PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D. | | | | | | | | |
| 22a. BURIAL Cremation REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 11, 1960 | | 22c. NAME OF CEMETERY OR Crematory Arlington National | | 22d. LOCATION (City, town, or county) Arlington, Virginia. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS | | ADDRESS CO. Riverdale, Md. | | 24a. REC'D BY REGISTRAR FEB 10 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2183

CERTIFICATE OF DEATH

Reg. Dist. No.

02118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|--|--|--|---|---|---|
| 1. PLACE OF DEATH o COUNTY Montgomery | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived - If institut on, Res dence before admission) a. STATE Maryland | | b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN lb 53 hr. 1 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton | | d. STREET ADDRESS Pebble School Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Baby | Middle Boy | Last Boswell | 4. DATE OF DEATH February 21 | Month February | Day 21 | Year 1960 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 18, 1960 | 9. AGE (In years last birthday) — yrs. — months — days | 10. IF UNDER 1 YEAR Months 2 | 11. IF UNDER 24 HRS Hours 53 | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 13. FATHER'S NAME Anthony L. Boswell Jr. | | 14. MOTHER'S MAIDEN NAME Martha Clara Simons | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | INFORMANT Martha C. Boswell | | Address Fulton, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7/15 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Prematurity (one of twins) | | Intracranial hemorrhage (rt. temporal region) | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| (c) DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/18 , 1960, to 2/21 , 1960, that I last saw the deceased alive on 2/21 , 1960, and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | | | | | |
| MEDICAL CERTIFICATION PHYSICIAN'S SIGNATURE Charles S. Whitaker, M.D. | | | | | | ADDRESS (Street, city or town, state) Clarksville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 2/22/60 | | 22b. DATE THEREOF 2/22/60 | | 22c. NAME OF CEMETERY OR CREMATORIY St. Louis Cemetery | | 22d. LOCATION (City, town, or county) Hagerstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Heath Funeral Home, Inc., Inc. | | ADDRESS 217 316 IX V3 | | 24a. REC'D BY REGISTRAR FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Koenig | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

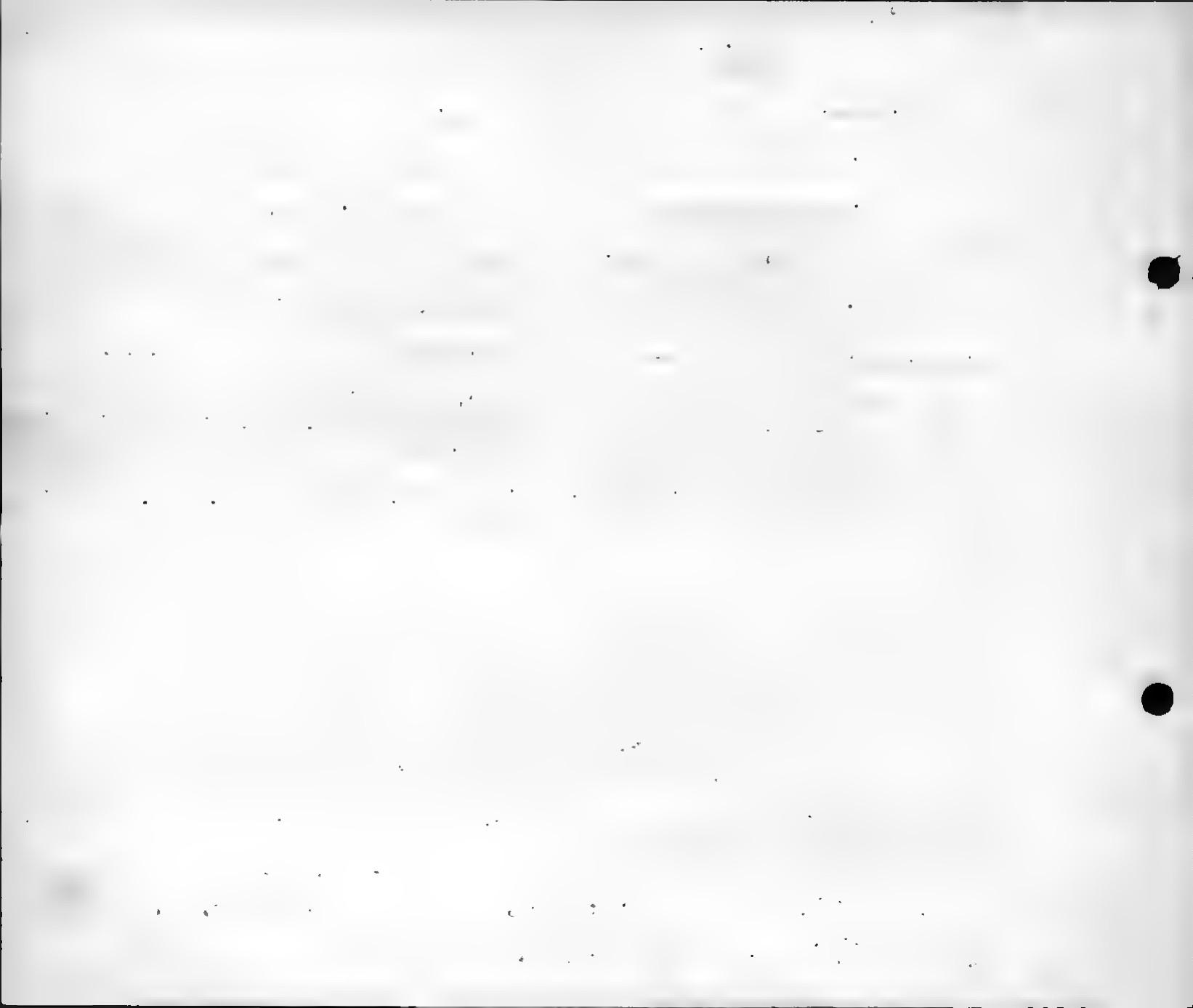
2189

CERTIFICATE OF DEATH

Reg. Dist. No.

e2119

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 19 hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Moses | Middle Eli | Last Boyd |
| 4. DATE OF DEATH | Month February | Day 9 | Year 1960 |
| 5. SEX male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH August 8, 1880 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) day laborer | 10b. KIND OF BUSINESS OR INDUSTRY --- | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Boyd | 14. MOTHER'S MAIDEN NAME Rachel Prather | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. yes | INFORMANT Rachel Macabée | INTERVAL BETWEEN ONSET AND DEATH 13 months Bilateral Blindness 3 days |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb 8, 1960 , to Feb 9, 1960 , that I last saw the deceased alive on Feb 9, 1960 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE P.P. Andrews | ADDRESS (Street, city or town, state) 4201 Eastmond St. N.E. Washington D.C. | | |
| PHYSICIAN'S NAME (Type) P.P. Andrews | DATE SIGNED 2-15-60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/14/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Ash Memorial | 22d. LOCATION (City, town, or county) (State) Sandy Spring, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Burden | ADDRESS Bethesda, Md. | 24a. REC'D BY REGISTRAR DATE FEB 15 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas |



1 X

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

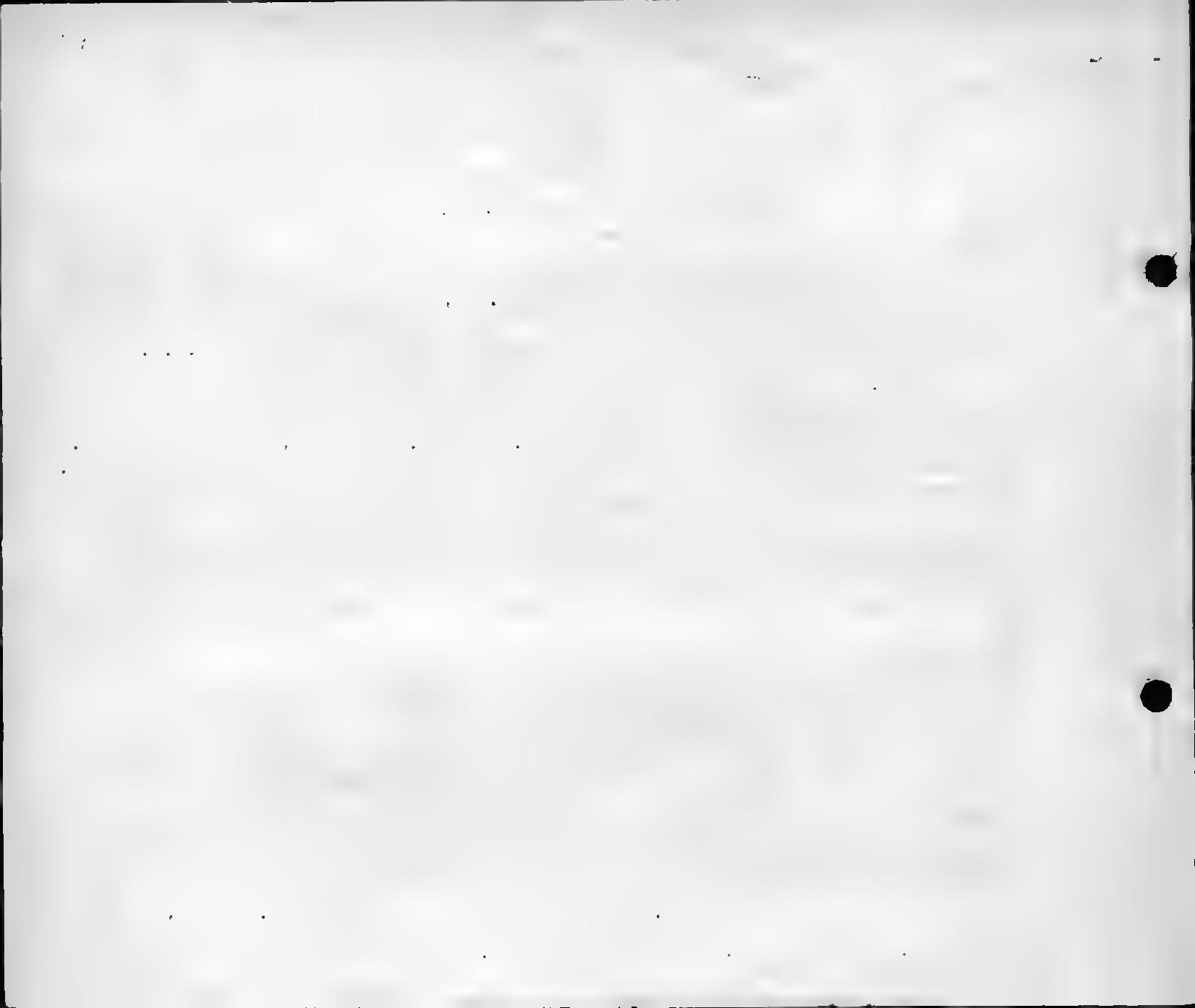
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. _____

02120

| | | | | | |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2136 | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) | |
| Montgomery | | MARYLAND | | a. STATE | b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Tahoma Park | | 10 A | | Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | d. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Marsh San. & Soap | | 1816 Richmond Ctr | | | |
| e. NAME OF DECEASED (Type or print) | | First | Middle | Lost | 4. DATE OF DEATH |
| Henry J. Brandlein | | | | | Feb 18 1960 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 70 yrs |
| Male | | white | | Oct. 13, 1889 | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Cabinet maker | | | | New York | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Christian Brandlein | | Francesca Fickert | | U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | |
| No | | 100-07-9423 | | Mrs. Pearl E. Brandlein, 816 Richmond Ave. Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 20g. DATE OF DEATH 20h. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | Frank J. Brandlein | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | FRANK J. BOSCH | | DATE SIGNED 2-19-60 | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/22/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. PIMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR FEB 23 '60 | |
| Raymond J. Pimphrey | | | | 24b. REGISTRAR'S SIGNATURE Charles S. Kline | |
| VS. A15ME 5M 2/57 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

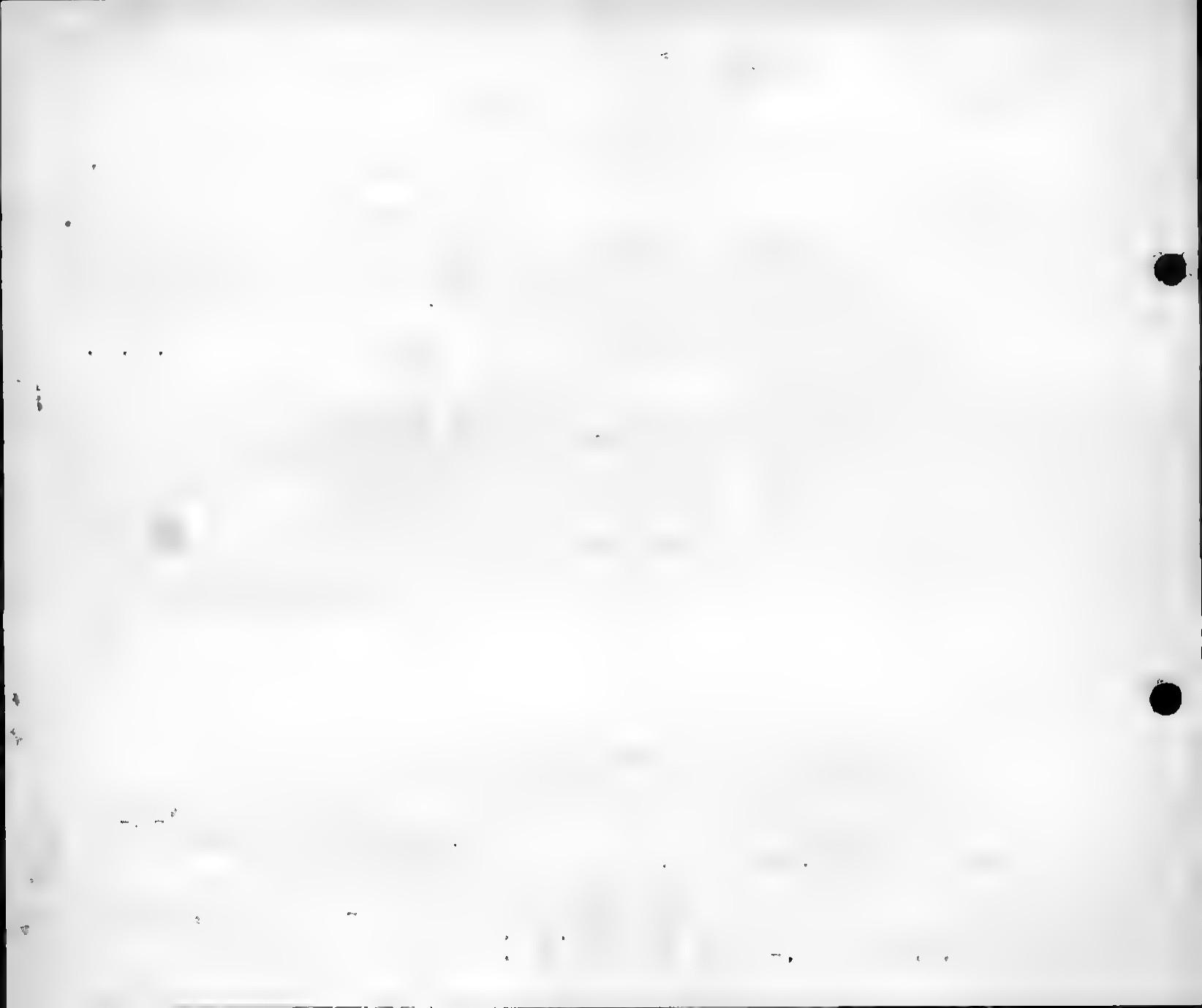
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02121

| | | | | | | | |
|--|----------------------------------|--|--|--|--|--|----------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE District of Columbia | | b. COUNTY | |
| b. C. T. Y. OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 84 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16 (Westgate, Md.) | | d. STREET ADDRESS 5011 Jamestown Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Nancy | | First | Middle | Last | 4. DATE OF DEATH February 26, 1960 | Month | Day Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 21, 1920 | | 9. AGE (in years last birthday) 39 yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician | | 10b. KIND OF BUSINESS OR INDUSTRY Laboratory | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Claudius Murchison | | 14. MOTHER'S MAIDEN NAME Constance Waterman | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| Respiratory failure Diffuse Circumvagbras Carcinoma of Breast | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 1, 1959 , to February 26, 1960 , that I last saw the deceased alive on February 26, 1960 , and that death occurred at 1:05 P.M. from the causes and on the date stated above | | | | | | | |
| ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| DATE SIGNED 2-26-60 | | | | | | | |
| ACTUAL SIGNATURE Claud Murchison, M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) LOUIS V. AVIOLI, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/1/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem. - Arlington, Virginia | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W. | | ADDRESS Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE FEB 29 1960 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

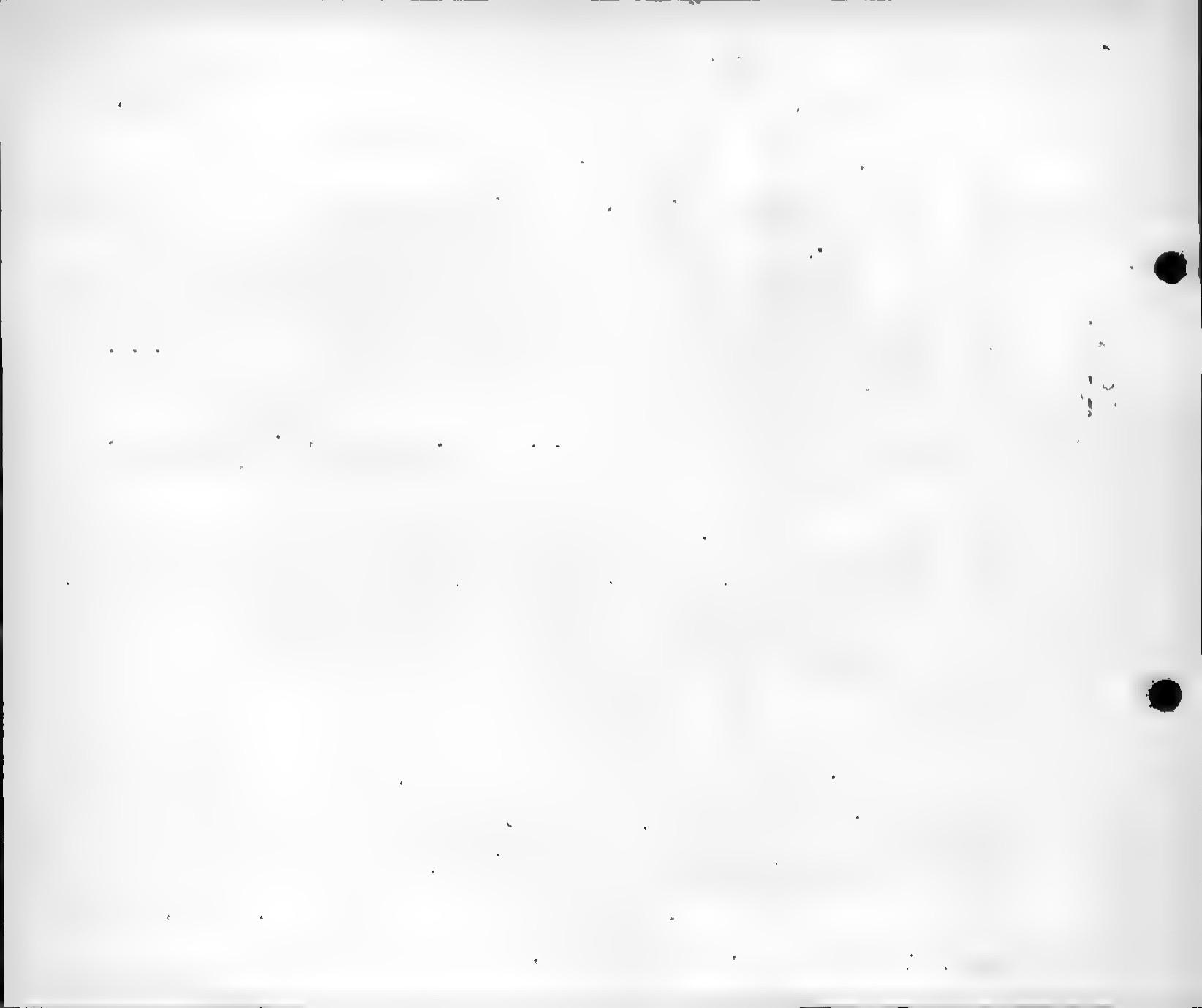
2167

CERTIFICATE OF DEATH

Reg. Dist. No.

02122

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admis'sn) a. STATE MARYLAND | |
| | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | |
| | | c. LENGTH OF STAY IN b Since Sept. 1959 | |
| | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS REST HOME | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First H. | Middle ALBERT | Last BUHLER |
| 4. DATE OF DEATH | Month Feb | Day 15 | Year 1960 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/19/73 |
| 9. AGE (In years last birthday) 86 yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer (retired) | 10b. KIND OF BUSINESS OR INDUSTRY Owner of Grocery Store | 11. BIRTHPLACE (State or foreign country) GERMANY |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME FRIEDRICH BUEHLER | 14. MOTHER'S MAIDEN NAME KAROLINE GOLDNER | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. NONE | INFORMANT Mrs. Alma B. Schaeffer, 1613 Oaklawn Ct. | Address Silver Spring, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22 IX Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>Spinal arteries closed</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 days | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Apr</i> , 1960, to <i>15 Feb</i> , 1960, that I last saw the deceased alive on <i>12 Feb</i> , 1960, and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>M B Queen</i> | M.D. | ADDRESS (Street, city or town, state) <i>7112 Willow Ave, Takoma Park, MD</i> | |
| PHYSICIAN'S NAME (Type) <i>M B Queen</i> | DATE SIGNED <i>15 Feb 1960</i> | | |
| 22a. BURIAL CREMATION CREMATION | 22b. DATE THEREOF 2/18/60 | 22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. <i>Raymond B. Zinko</i> | ADDRESS SILVER SPRING, MARYLAND | 24a. REC'D BY REGISTRAR DATE FEB 17 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 221 4276 2-25-60 et

02123

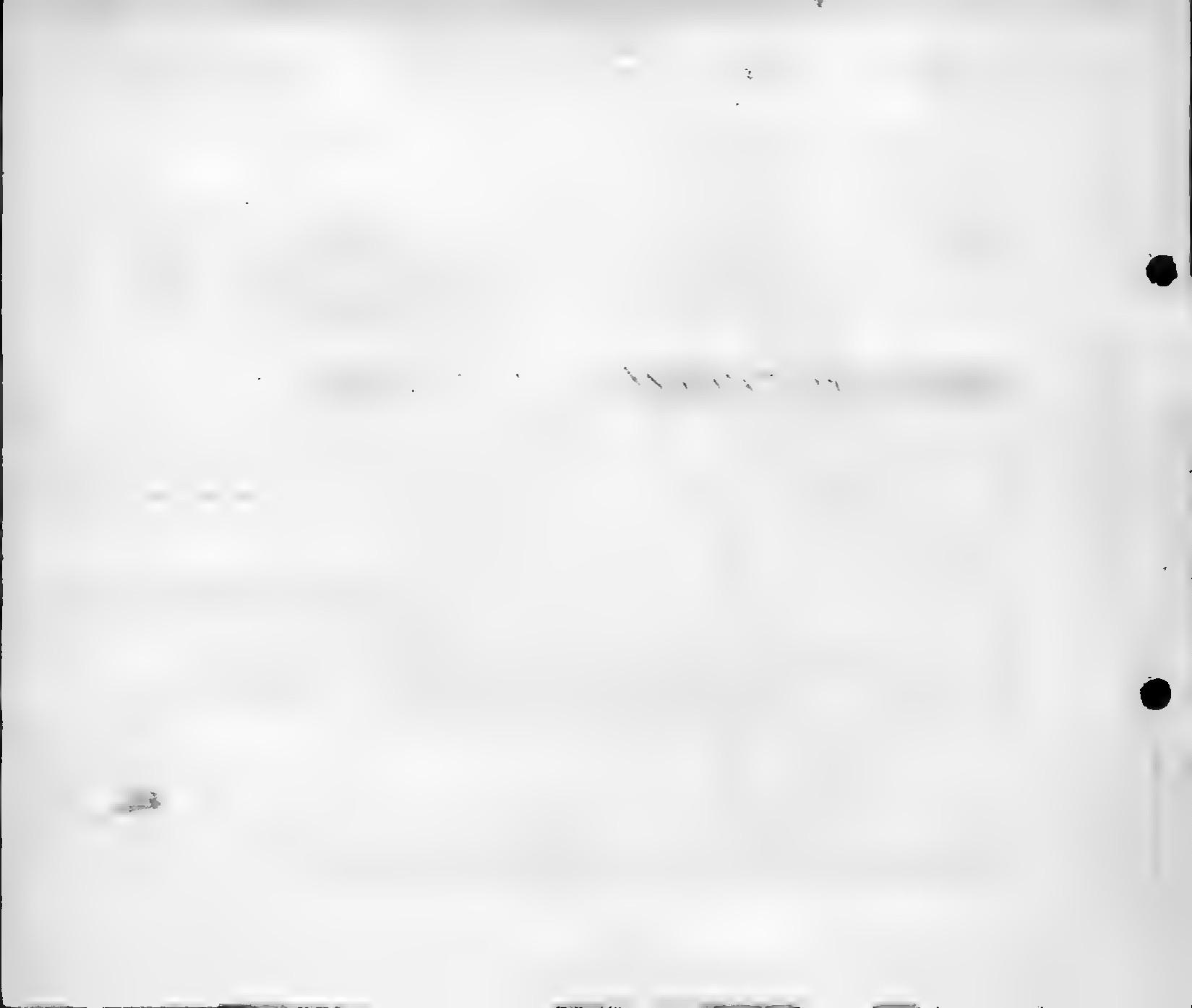
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE | |
| Montgomery Maryland | | Maryland Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | c. LENGTH OF STAY IN 16 10 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14 Md. | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| Elizabeth Lerch Callan | | | Last |
| 4. DATE OF DEATH | | Month | Day |
| | | Feb | 6 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| FEMALE | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 12/25/81 | | 78 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Housewife | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | WASHINGTON, DC United States | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| John J. Lerch | | Catherine Lepper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| No | | 17. INFORMANT | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Address | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | PULMONARY HEMORRHAGE | |
| (b) | | INTERVAL BETWEEN ONSET AND DEATH min. | |
| DUE TO | | PNEUMONIA | |
| (c) | | 4 weeks | |
| DUE TO | | CON. HEART FAILURE COMP. | |
| DUE TO | | 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from | | ADDRESS (Street, city or town, state) | |
| alive on | | DATE SIGNED | |
| ACTUAL SIGNATURE | | P.J. Brennan, Bethesda, Md. 7/6/60 | |
| PHYSICIAN'S NAME (Type) | | A.J. BRENNAN | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORIAL | | 22d. LOCATION (City, town, or county) | |
| REMOVAL (Specify) | | DATE | |
| 22e. ADDRESS | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REG'D BY REGISTRAR | |
| O. Gafford | | DATE | |
| ADDRESS | | 475 H St NW | |
| 24b. REGISTRAR'S SIGNATURE | | Arthur S. Turner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168

CERTIFICATE OF DEATH

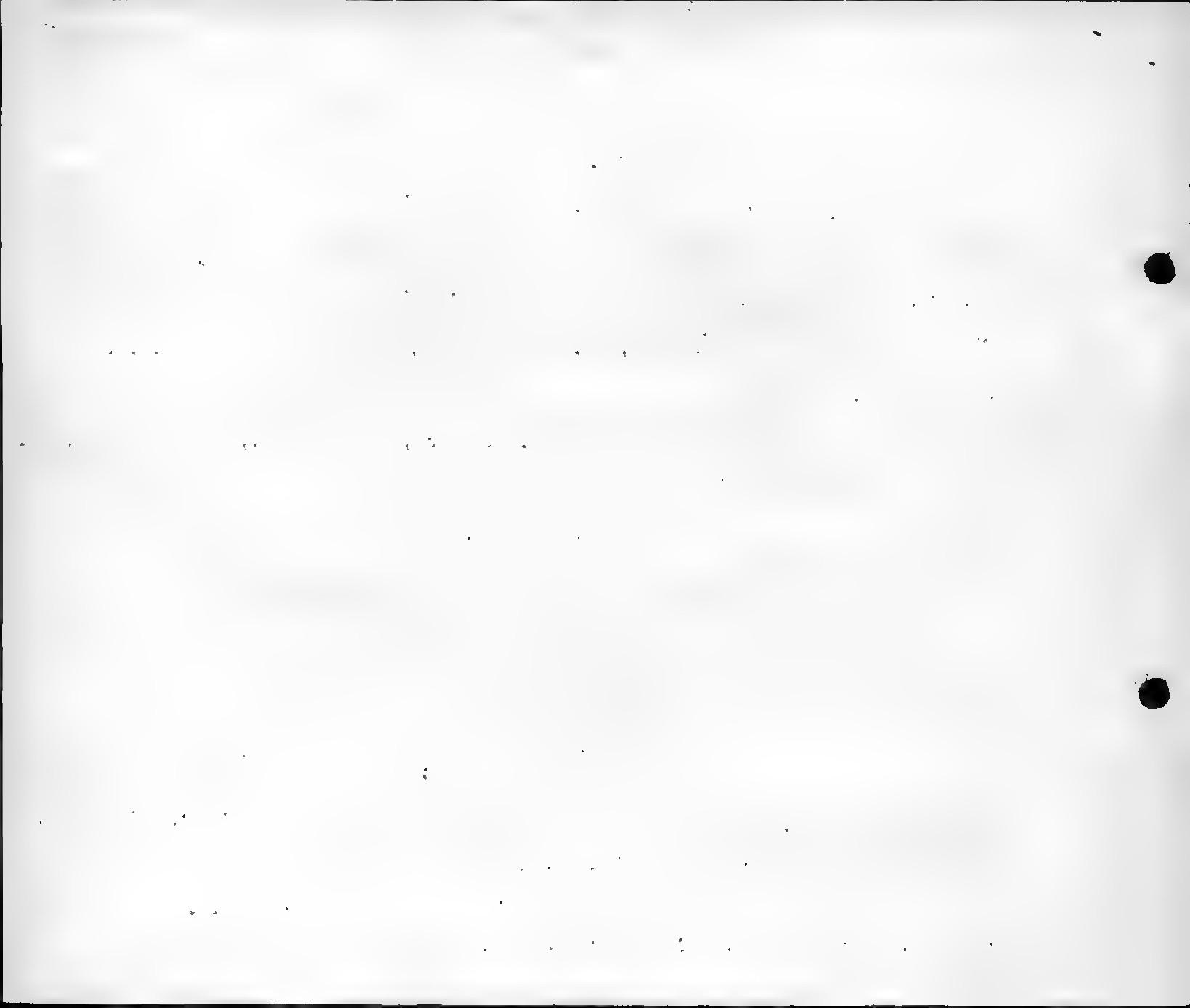
02124

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: That law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. LENGTH OF STAY IN 1b one week | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanit. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| f. STREET ADDRESS 315 LEIGHTON AVENUE | | g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mamie ELIZABETH | | First Mamie | Middle ELIZABETH |
| | | Last Chase | 4. DATE OF DEATH Month February 1 |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Sep 9, 1872 | | 9. AGE (In years (last birthday) 87) yrs. | 10. IF UNDER 1 YEAR Months 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY ASSESSOR'S OFFICE Rockville, Md. | 11. BIRTHPLACE (State or foreign country) Trenton, Illinois |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JEFFERSON C. POWERS | |
| 14. MOTHER'S MAIDEN NAME MARY ELY | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mr. Ben Shaw, 21 Shaw Ave., Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 | | 19. INTERVAL BETWEEN ONSET AND DEATH 12 HOURS | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic debilitation | | (b) DUE TO Chronic heart failure, compensated | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | (County) 10609 Concord Street (State) Feb 1, 1960 | |
| 21. I certify that I attended the deceased from Jan 26 , 1960, to Feb 1 , 1960, that I last saw the deceased alive on Feb 1 , 1960, and that death occurred at 11:35 AM from the causes and on the date stated above | | ADDRESS (Street, city or town, state) Robert T. Thibadeau, M.D., Kensington, Maryland | |
| ACTUAL SIGNATURE <i>Robert T. Thibadeau</i> | | DATE SIGNED Feb 1, 1960 | |
| PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. | | 22b. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2/4/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY | | 22d. LOCATION (City, town or county) (State) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMFIREY, INC. | | 24a. REC'D BY REGISTRAR Raymond J. Ziska ADDRESS SILVER SPRING, MD. 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas DATE FEB 4 '60 | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2192

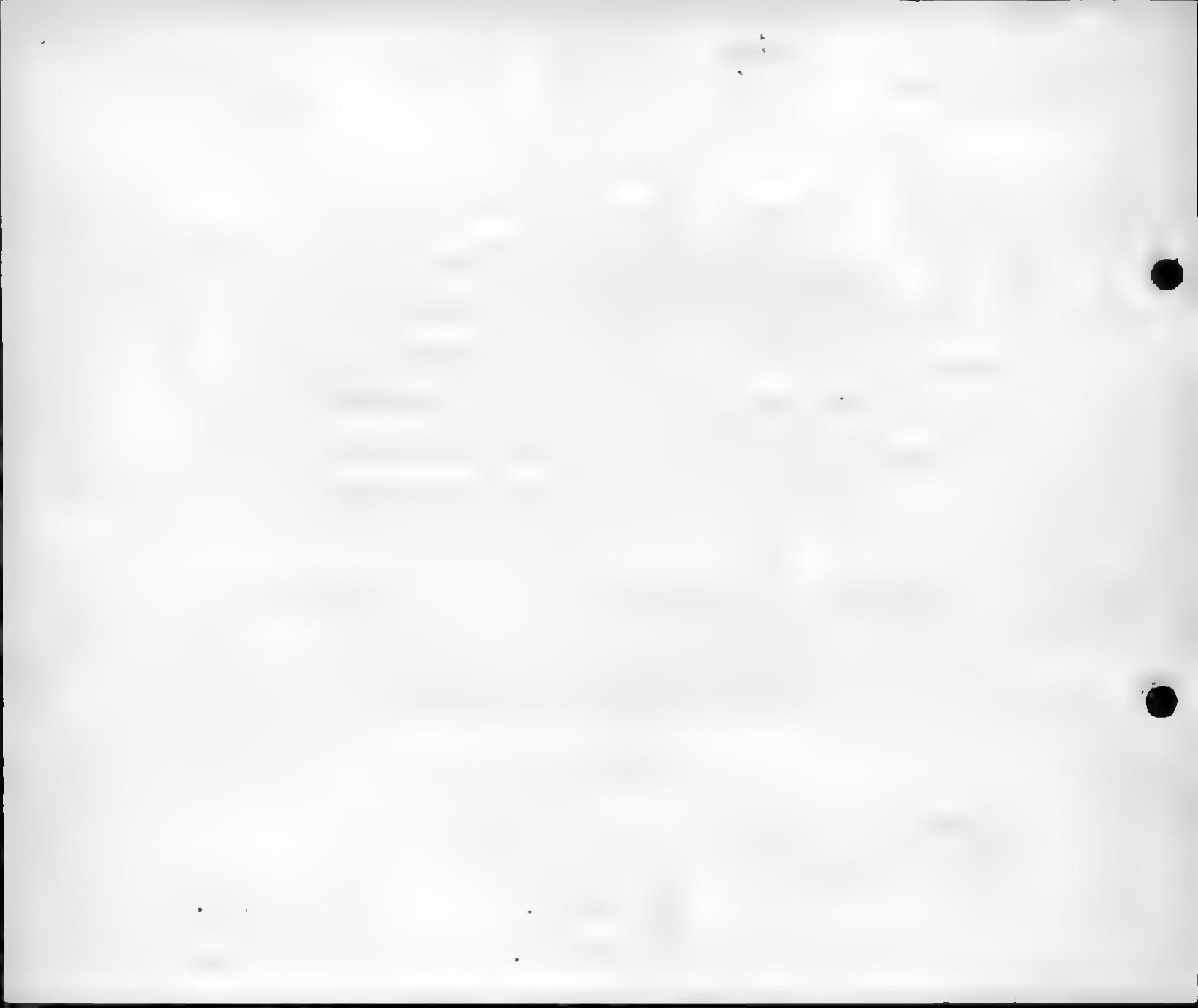
CERTIFICATE OF DEATH

Reg. Dist. No.

02125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

| | | | | | | | | |
|---|--|---|---|--|--|---|-------------------------------------|---------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 7 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WHITE OAK | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. | | | | d. STREET ADDRESS RT. #2 STEWART LANE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) RUTH | | First | Middle | Last | 4. DATE OF DEATH FEBRUARY 12 19 60 | Month | Day | Year |
| 5. SEX FEMALE | | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 3/15/04 | 9. AGE (In years last birthday) 55 yrs | E. FUNDER 1 YEAR Months 5 | IF UNDER 24 HRS Days 5 | Hours Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CHARLES HENRY JACKSON | | | | 14. MOTHER'S MAIDEN NAME CINDERELLA JACKSON | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | | INFORMANT | | Address OLNEY, MD. | | |
| HOSPITAL RECORDS | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX WITH METASTASES INTERVAL BETWEEN ONSET AND DEATH 171X 1 YEAR DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from FEB. 5 19 60 to FEB. 12 19 60 , that I last saw the deceased alive on FEB. 12 19 60 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND | | | | | | | | |
| ACTUAL SIGNATURE | | DATE SIGNED 2/13/60 | | | | | | |
| PHYSICIAN'S NAME (Type) C. H. LIGON, M. D. | | 22c. LOCATION (City, town, or county) Rockville, Md. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/15/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Park, | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR FEB 18 '60 | | 24b. REGISTRAR'S SIGNATURE | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2137

CERTIFICATE OF DEATH

Reg. Dist. No.

0126

| | | | | | |
|---|---|---|---|--|-------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE <i>MARYLAND</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md</i> | c. LENGTH OF STAY IN 1b <i>8 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District of Columbia</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Washington Sanitarium & Hospital</i> | e. STREET ADDRESS <i>7611 Georgia Ave, N.W.</i> | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>George Harvey</i> | First <i>George</i> | Middle <i>Harvey</i> | Last <i>Clark</i> | | |
| 4. DATE OF DEATH <i>February 16 1960</i> | Month <i>February</i> | Day <i>16</i> | Year <i>1960</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Cauc.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7-8-96</i> | | |
| 9. AGE (in years lost birthday) <i>23 yrs</i> | 10. IF UNDER 1 YEAR Months <i>23</i> | 11. IF UNDER 24 HRS Days <i>0</i> | 12. IF UNDER 24 HRS Hours <i>0</i> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Fireman</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>James Clark</i> | 14. MOTHER'S MAIDEN NAME <i>Laura Goddard</i> | Address | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>None</i> | INFORMANT <i>Wife - Mrs. Margaret Clark - same as above</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized peritonitis</i> DUE TO <i>540.1</i> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>two recently perforated gastric ulcers</i> (c) <i>congestive cardiac failure</i> | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary sclerosis with occlusion; myocardial insufficiency</i> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>_____</i> | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>_____</i> | 20f. (City or town) <i>_____</i> | (County) <i>_____</i> | (State) <i>_____</i> |
| 21. I certify that I attended the deceased from <i>Mar. 1958</i> to <i>Feb 16 1960</i> that I last saw the deceased alive on <i>FEB 16 1960</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) <i>7733 Massachusetts Ave NW Wash 12 D.C.</i> | | | | | |
| DATE SIGNED <i>FEB 17 1960</i> | | | | | |
| ACTUAL SIGNATURE <i>Robert L. Krichmar</i> | PHYSICIAN'S NAME (Type) <i>Robert L. Krichmar</i> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2/19/60</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i> | 22d. LOCATION (City, town, or county) <i>Brentwood Md.</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Krichmar Co. of Maryland</i> | | ADDRESS <i>1400 Charles St. Baltimore MD</i> | 24a. REC'D BY REGISTRAR <i>REG 13 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>John S. Jones</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

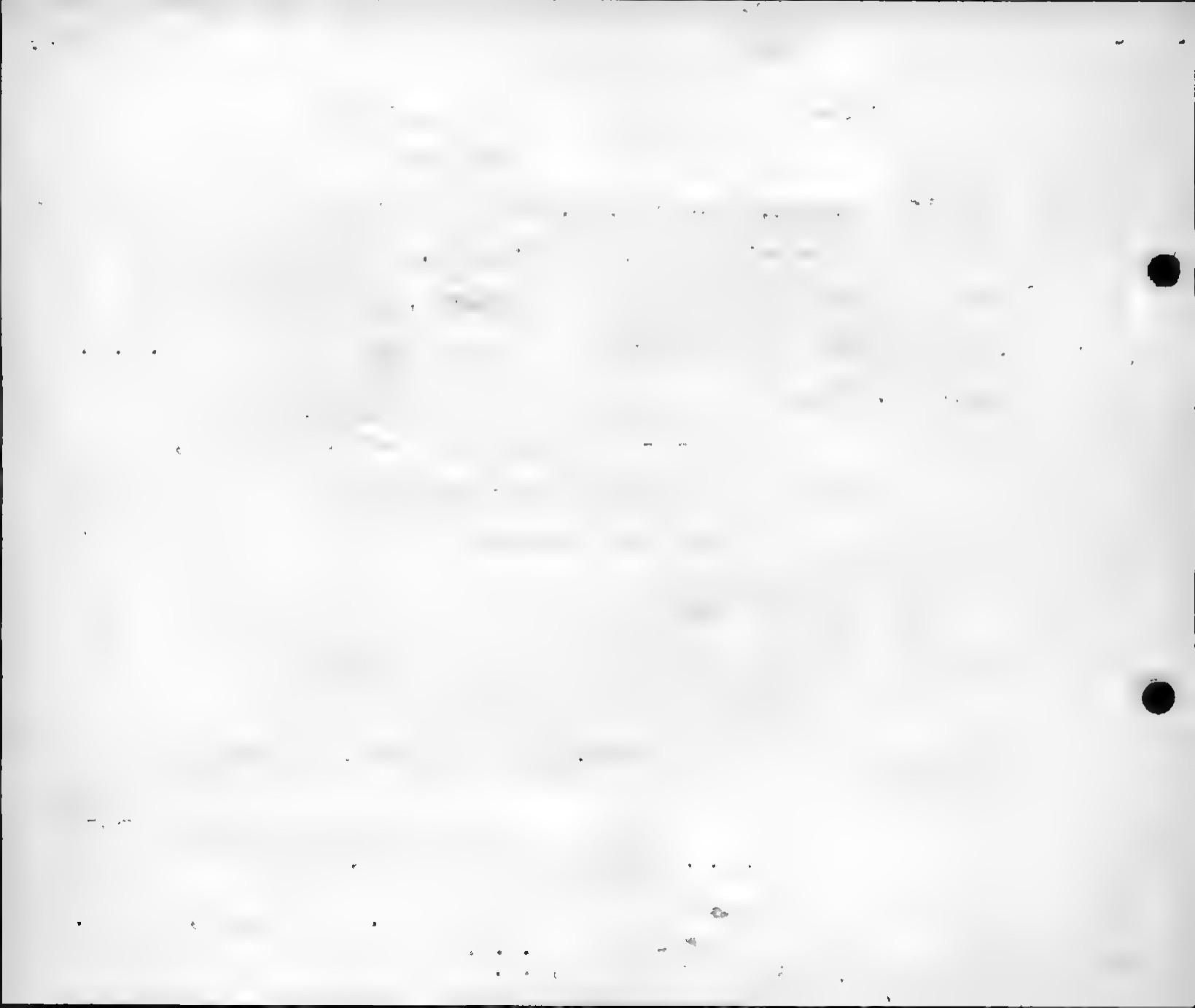
2193

CERTIFICATE OF DEATH

Reg. Dist. No.

02127

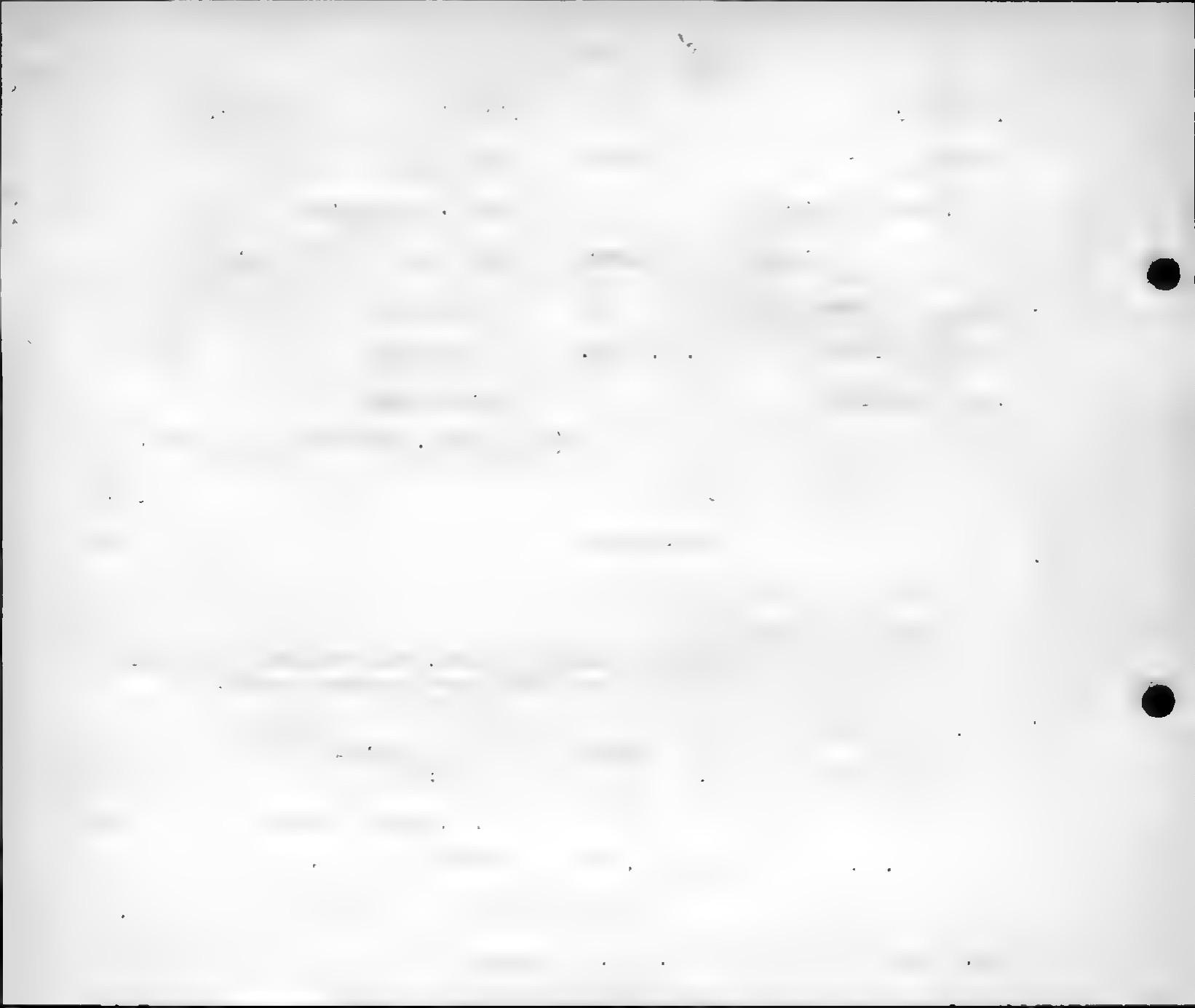
| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|-------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) b. STATE Pennsylvania | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Ridley Park | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c LENGTH OF STAY IN lb 48 days | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. STREET ADDRESS 604 Morgan Avenue | |
| 3. NAME OF DECEASED (Type or print) | First Benjamin | Middle Frank | Last Colten, Sr. | 4. DATE OF DEATH February | Month 26 | Day 19 | Year 60 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | b. DATE OF BIRTH October 3, 1877 | 9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months 02 | IF UNDER 24 HRS. Hours 00 | Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton & Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Benjamin S. Colten | | | | 14. MOTHER'S MAIDEN NAME Catherine Rhodes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 196-14-4102 | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Metastatic Chondrosarcoma (c) DUE TO Hemorrhagic Broncho-Pneumonia | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Hours 1 Year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 9, 1960 , to February 26, 1960 that I last saw the deceased alive on February 26, 1960 , and that death occurred at 7:00 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 2-27-60 | | | | | | | |
| ACTUAL SIGNATURE <i>Saul Genuth</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) SAUL GENUTH, M.D. | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/1/1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM Union Presbyterian Cem. | | 22d. LOCATION (City, town or county) Kirkwood, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C. | | | | | | | |
| | | | | 24a. REC'D BY REGISTRAR MAR 1 '60 | | 24b. REGISTRAR'S SIGNATURE Orilia & Kraus | |



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in event within 72 hours after death

Montgomery Co., Deputy Medical Examiner notified.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | Reg. Dist. No. 215 | 02128 | |
|--|--|---|--|--|--|---|--|---|---|--|-------|--|
| 2194 CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia | | | | | b. COUNTY Arlington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | | c. LENGTH OF STAY IN 1b 44 days | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | e. STREET ADDRESS 4439 N. 17th Street | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First William | Middle Edward | Last CORFITZEN | 4. DATE OF DEATH February 4 1960 | | Month February | Day 4 | Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-4-08 | | 9. AGE (In years last birthday) 52 yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service | | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | | 11. BIRTHPLACE (State or foreign country) New York | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Edward CORFITZEN | | | 14. MOTHER'S MAIDEN NAME Theresa KEEGAN | | | INFORMANT (W) Regina D. Corfitzen, same as #2 above | | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. ----- | | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia <i>357X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syringomyelia DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| 18. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Left Hip | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell while walking at home. Fall was due to instability caused by his central nervous system disease. | | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:25 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. Home | | | 20f. (City or town) Arlington (County) Virginia (State) | | | |
| 21. I certify that I attended the deceased from December 22, 1959 , to February 4, 1960 , that I last saw the deceased alive on February 3, 1960 , and that death occurred at 2:00 AM , from the causes and on the date stated above | | | ADDRESS (Street, city or town, state) | | | DATE SIGNED 2-4-60 | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Dawson II</i> | | | M.D. U. S. Naval Hospital | | | | | | | | | |
| PHYSICIAN'S NAME (Type) F. J. DAWSON II, LT, MC, USN | | | Bethesda 14, Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial | | 22b. DATE THEREOF 2-8-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Columbia Gardens | | 22d. LOCATION (City, town, or county) Arlington | | (State) Va. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Gawler Sons</i> | | ADDRESS Hos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC | | 24a. REC'D BY REGISTRAR FEB 8 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Carroll S. Pirnia</i> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

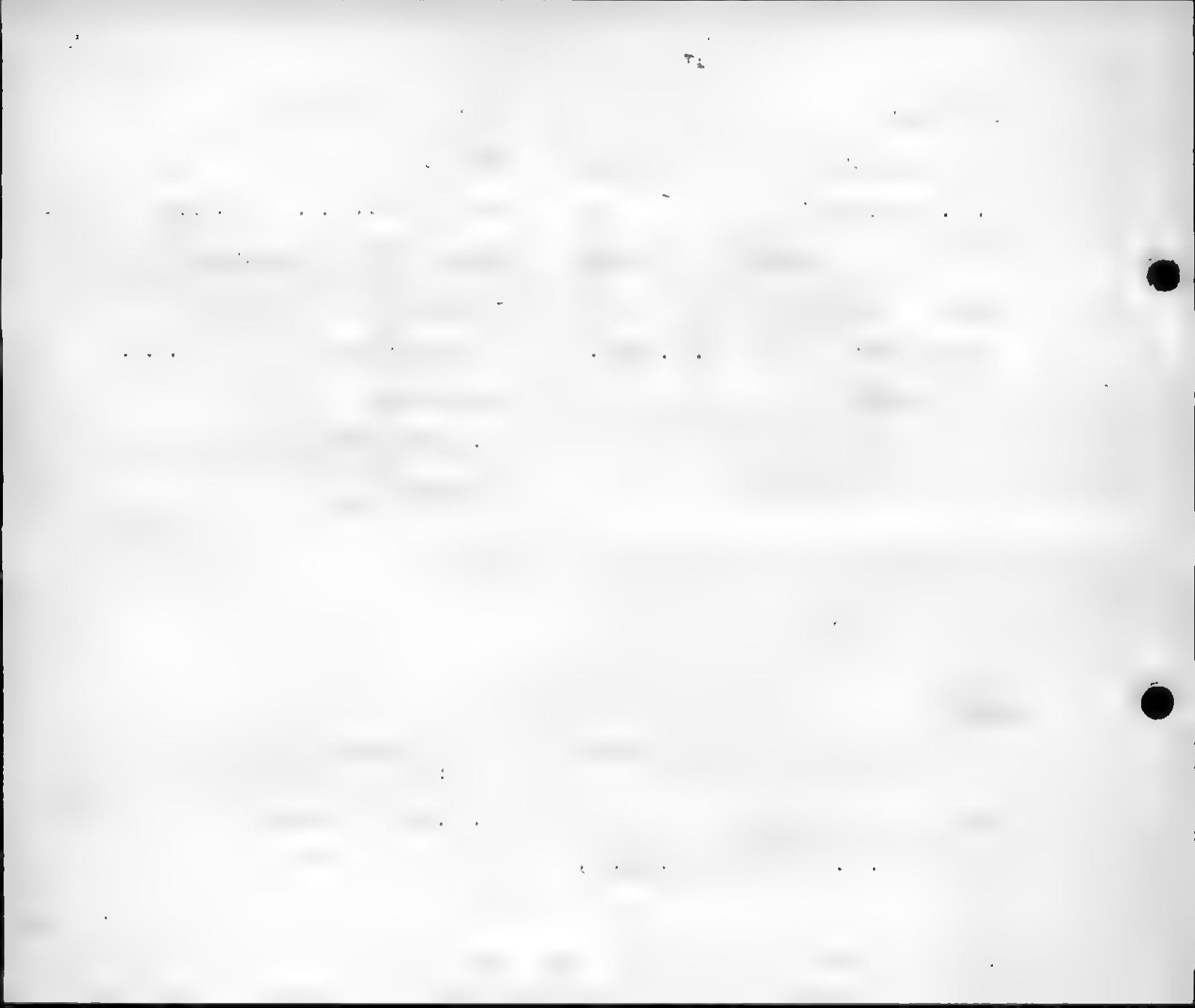
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2195 CERTIFICATE OF DEATH

Reg. Dist. No. 215

02129

| | | | | | | | |
|---|---|--|--|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE District of Columbia | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 33 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 47x 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | d. STREET ADDRESS 3023 14th St., N.W. - Apt. 713 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First FRANCES | Middle SHEERS | Last CRAMER | 4. DATE OF DEATH February 11 1960 | Month Day Year | Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-16-93 | 9. AGE (In years last birthday) 67 yrs | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (State or foreign country) Connecticut | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel SHEERS | | 14. MOTHER'S MAIDEN NAME Rosaland BURKO | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None | INFORMANT (H) J. A. Cramer, same as #2 above | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Diabetes mellitus | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Peripheral vascular disease & gangrene AS HD | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. January 9, 1960 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital | 20f. (City or town) Bethesda | (County) Maryland | (State) Md. | | |
| 21. I certify that I attended the deceased from January 9, 1960 , to February 11, 1960 , that I last saw the deceased alive on February 11, 1960 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>R. G. Galbraith Jr.</i> | | | | ADDRESS (Street, city or town, state) U. S. Naval Hospital | | DATE SIGNED 2-11-60 | |
| PHYSICIAN'S NAME (Type) R. G. GALBRAITH, JR., LT, MC, USN | | BETHESDA 14, Maryland | | | | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) Cremation | 22b. DATE THEREOF 2-13-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Crematory | 22d. LOCATION (City, town, or county) Prince Georges Co. Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines Funeral Home</i> | ADDRESS 2901 14th St. NW, WashDC | 24a. REC'D BY REGISTRAR FEB 15 '60 | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i> | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

2195 CERTIFICATE OF DEATH

Reg. Dist. No.

02130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|--|---|---|---|---|----------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MD | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG | c. LENGTH OF STAY IN 1b 15 YRS | b. COUNTY MONTGOMERY | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLARKSBURG | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CLARKSBURG RT 1 | e. STREET ADDRESS RT 1 | d. STREET ADDRESS RT 1 | | | | |
| 3. NAME OF DECEASED (Type or print) Jda JANE CRANFORD | | 4. DATE OF DEATH 2 8 1960 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| S. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 31 1879 | | | |
| 9. AGE (in years last birthday) 80 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) MD | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME THOMAS E MOXLEY | 14. MOTHER'S MAIDEN NAME ANNA RILEY | INFORMANT HORACE WILLIAMS | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. 155-1 | Address FREDERICK MD | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO METASTATIC CANCER OF LIVER | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO PRIMARY CANCER OF GALL BLADDER | | | | | | |
| DUE TO OBILIE DUCTS | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18.) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month Day 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) DAIRY | (County) FR | (State) MD |
| 21. I certify that I attended the deceased from October 5, 1957 , to Feb 8, 1960 , that I last saw the deceased alive on Feb 7, 1960 , and that death occurred at 6135 MD , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) MAIN STREET | DATE SIGNED 2/8/60 | |
| ACTUAL SIGNATURE G. Meadors, MD | PHYSICIAN'S NAME (Type) G.F. MEADORS, MD | | DAIRY, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/10/60 | 22c. NAME OF CEMETERY OR CREMATORIAL MT OLIVET | 22d. LOCATION (City, town, or county) FREDERICK MD | (State) MD | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clara Lee Bandy | ADDRESS FREDERICK MD | 24a. REC'D BY REGISTRAR DATE Feb 11 '60 | 24b. REGISTRAR'S SIGNATURE Clara Lee Bandy | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2197

CERTIFICATE OF DEATH

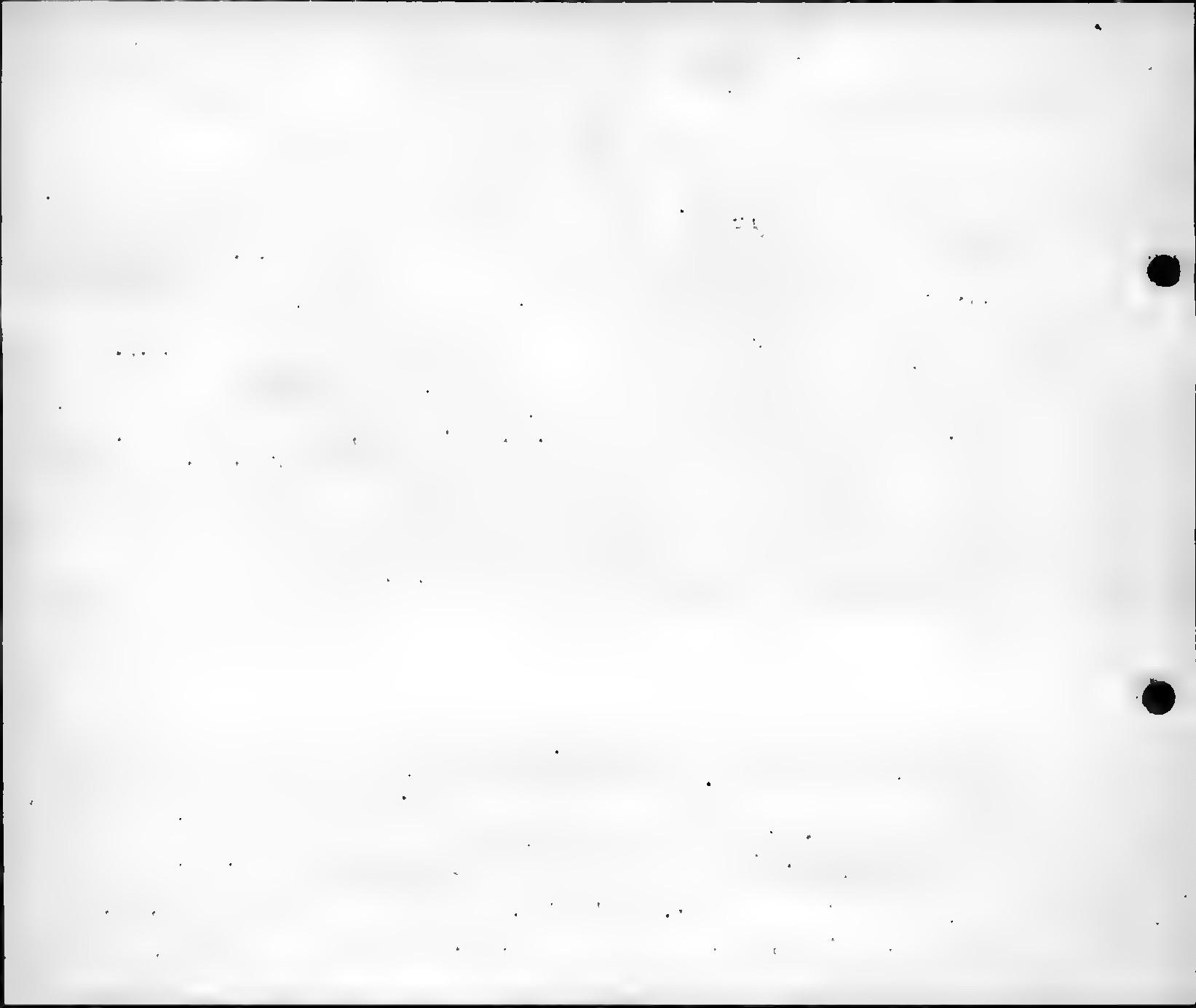
Reg. Dist. No.

02131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Log 4-
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN | c. LENGTH OF STAY IN MD since 1917 since 1917 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST GLEN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9805 ROSENSTEEL AVE. | d. STREET ADDRESS 9805 ROSENSTEEL AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) ETHEL | First MIDDLE MARIE | Last CULVER | 4. DATE OF DEATH FEB. 5 1960 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 4/9/98 |
| | | | 9. AGE (In years last birthday) 61 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 10c. BIRTHPLACE (State or foreign country) MARYLAND | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE HENRY CULVER | | 14. MOTHER'S MAIDEN NAME CAROLINE DOROTHY YODER GRAF | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO NONE | |
| | | INFORMANT Mr. F. Earl Culver, 3006 Homewood Pkwy. Kensington, Md. | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171X Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO of Carcinoma due to Carcinoma of Uterus with local metastasis. INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 1, 1959, to February 5, 1960, that I last saw the deceased alive on Feb 5, 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ACTUAL STATUS PHYSICIAN'S NAME (Type) JOHN J. CURRY | | ADDRESS (Street, city or town, state) 10670 Georgia Hall Rd. Grays Spring Rd. DATE SIGNED 10-6-70 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/8/60 | 22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CATH. CEMETERY | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Zinkai | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR DATE FEB 9 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Knapp |



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

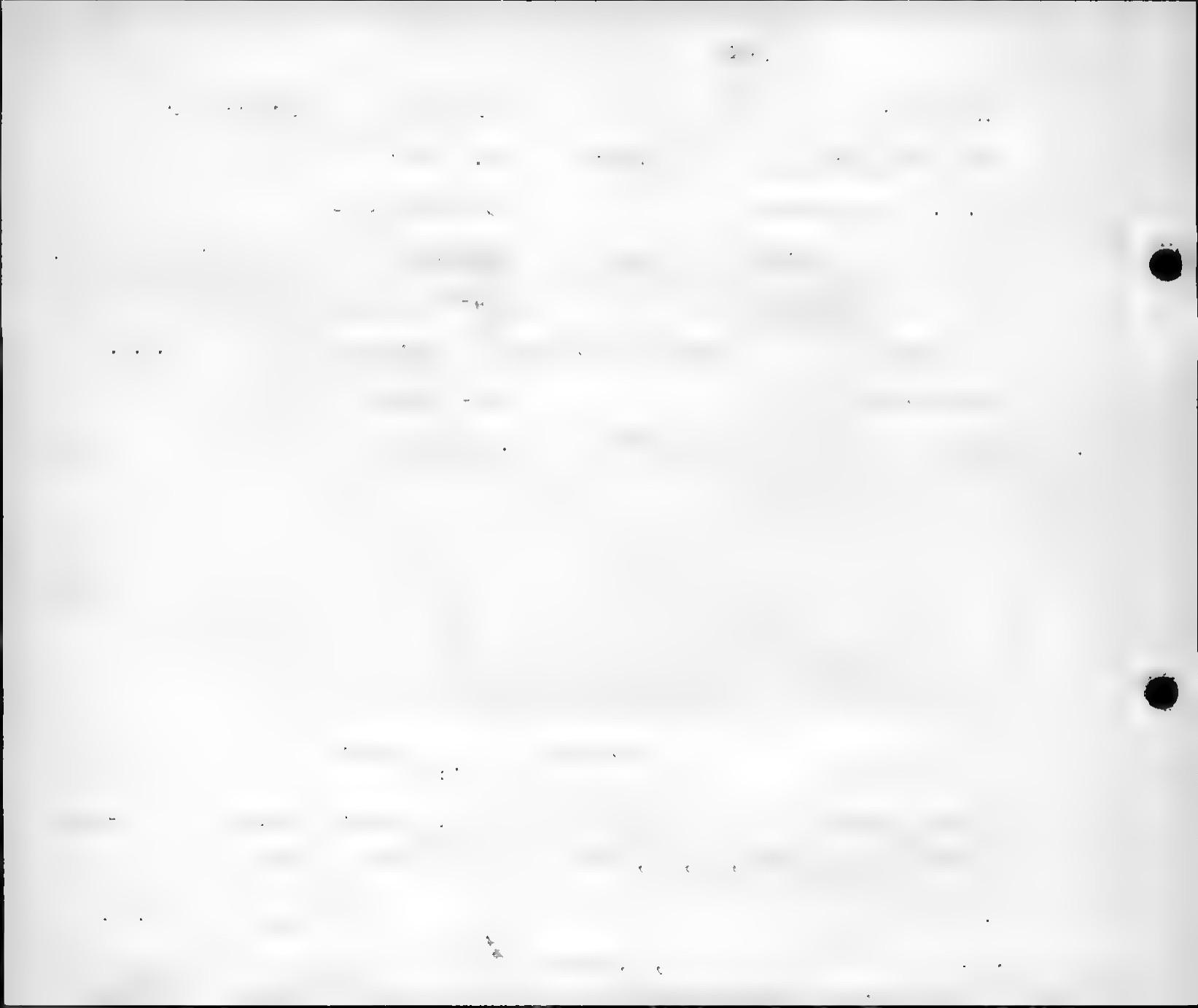
2198

CERTIFICATE OF DEATH

Reg. Dist. No.

02132
215

| | | | | | | | | | |
|---|--------------------------------------|---|--|--|--|---|-------------------------------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 156 days | | 2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Prince George | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier | | d. STREET ADDRESS 4504 31st Street | |
| 3. NAME OF DECEASED (Type or print) Orion | | First | Middle | Last | 4. DATE OF DEATH CURTIS | Month February | Day 12 | Year 1960 | |
| S. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 6-4-95 | 9. AGE (in years, months, birthday) 64 yrs | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | Min. 0 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, DC Police | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME James CURTIS | | | | 14. MOTHER'S MAIDEN NAME Alice Kempel | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO WWI 579-40-4807 | | INFORMANT Hospital Records | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post necrotic Cirrhosis DUE TO | | | | | | | | | |
| (c) Hepatitis DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from September 9, 1959 , to February 12, 1960 , that I last saw the deceased alive on February 11, 1960 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | | | | | | |
| DATE SIGNED | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Wood Davis</i> | | M.D. | | U. S. Naval Hospital | | 2-12-60 | | | |
| PHYSICIAN'S NAME (Type) John Wood DAVIS, LT, MC, USN | | | | Bethesda 14, Maryland | | | | | |
| 22a. BURIAL, CREMATON REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-15-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) Washington | | (State) D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S. H. Hines Co.</i> | | ADDRESS 2901 14th St., NW, Washington, DC | | 24a. REC'D BY REGISTRAR FEB 15 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i> | | | |
| VS A15 (4) 1SM 9/58 | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2199

CERTIFICATE OF DEATH

Reg. Dist. No.

02133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|--|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> | | b. COUNTY <u>Montgomery</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 16 <u>10 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8709 - Grant St.</u> | | d. STREET ADDRESS <u>8709 Grant St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret E. Danhakl</u> | | First <u>Margaret</u> | Middle <u>E.</u> | Last <u>Danhakl</u> | 4. DATE OF DEATH <u>2 - 7 - 1960</u> | Month <u>2</u> | Day <u>7</u> | Year <u>1960</u> |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-23-1882</u> | 9. AGE (In years last birthday) <u>77 yrs</u> | 10. IF UNDER 1 YEAR Months <u>0</u> | 11. IF UNDER 24 HRS. Hours <u>0</u> | 12. IF UNDER 24 HRS. Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John Frebert</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibert</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>John G. Danhakl</u> | | Address <u>8709 Grant St Bethesda Md</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adams-Stokes Syndrome</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> | | |
| 433.0 Conditions, if any, which gave rise to immediate cause (a), stating the year of dying cause last. (b) <u>Congestive Heart Failure (440)</u> | | DUE TO (b) <u>None</u> | | DUE TO (c) <u>None</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive Heart Failure (440)</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>1960</u> | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> | | 20f. (City or town) <u>None</u> | | (County) <u>None</u> (State) <u>None</u> |
| 21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>60</u> , to <u>7-7-1960</u> , that I last saw the deceased alive on <u>21-7-1960</u> , and that death occurred at <u>Bethesda</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>P. J. Brennan M.D.</u> PHYSICIAN'S NAME (Type) <u>P. J. BRENNAN</u> | | | | | | ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u> | | DATE SIGNED |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 2/10/60</u> | | 22b. DATE THEREOF <u>2/10/60</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>St. Mary's</u> | | 22d. LOCATION (City, town, or county) <u>Washington D.C.</u> | | (State) <u>D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u> | | ADDRESS <u>3605-14 St NW Washington, D.C.</u> | | 24a. REC'D BY REGISTRAR <u>FEB 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |



TO DEPUTY MEDICAL EXAMINER certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

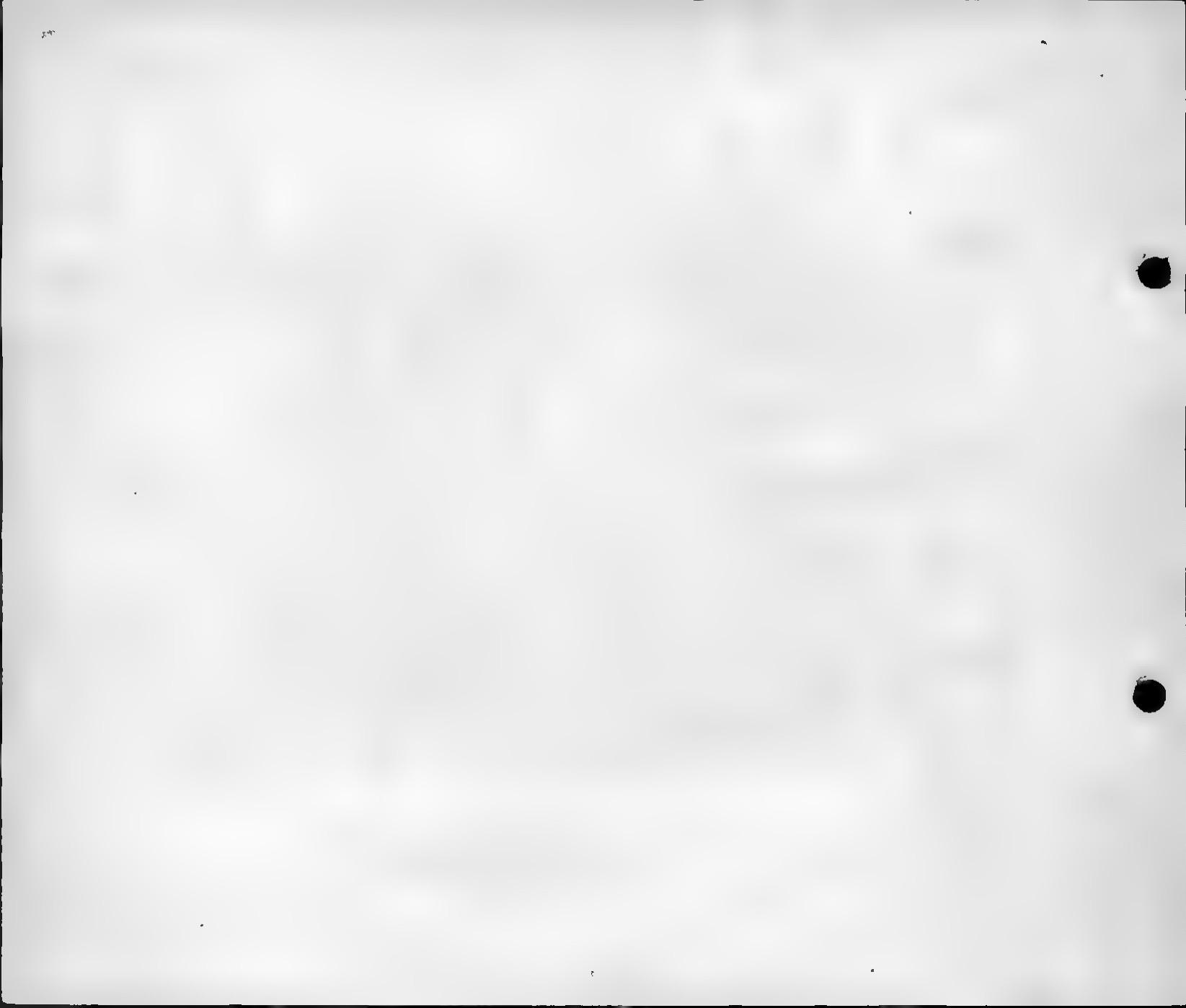
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02134

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) | |
| Montgomery Rockville | | a. STATE Md b. COUNTY Monty | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Rockville | | Rockville | |
| c. LENGTH OF STAY IN lb | | STREET ADDRESS | |
| 9 yr | | 521 W. Montgomery Ave | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 4. DATE OF DEATH | |
| 521 W. Montgomery Ave | | Mont 7 Feb 1960 | |
| 3. NAME OF DECEASED (Type or print) | | 5. SEX | |
| Frank Isaac Davis | | 6. COLOR OR RACE | |
| Male white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH | |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| | | Sept 4 1885 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years last birthday) | |
| County official retired | | 74 yrs. | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 10. BIRTHPLACE (State or foreign country) | |
| | | Md | |
| 11. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Horace Davis | | Emma Williamson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | 217-38-7502 | |
| 17. INFORMANT | | Address | |
| Susie Davis (wife) Item 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | sudden | |
| 420.1 | | Coronary occlusion | |
| DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | (b) | |
| | | (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 19 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | DATE SIGNED | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) FRANK J. BROSCHEIT | | Feb 7, 1960 | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/10/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery | | 22d. LOCATION (City, town, or county) Beallsville, Maryland (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE FEB 9 '60 24b. REGISTRAR'S SIGNATURE Anthony S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02135

2200

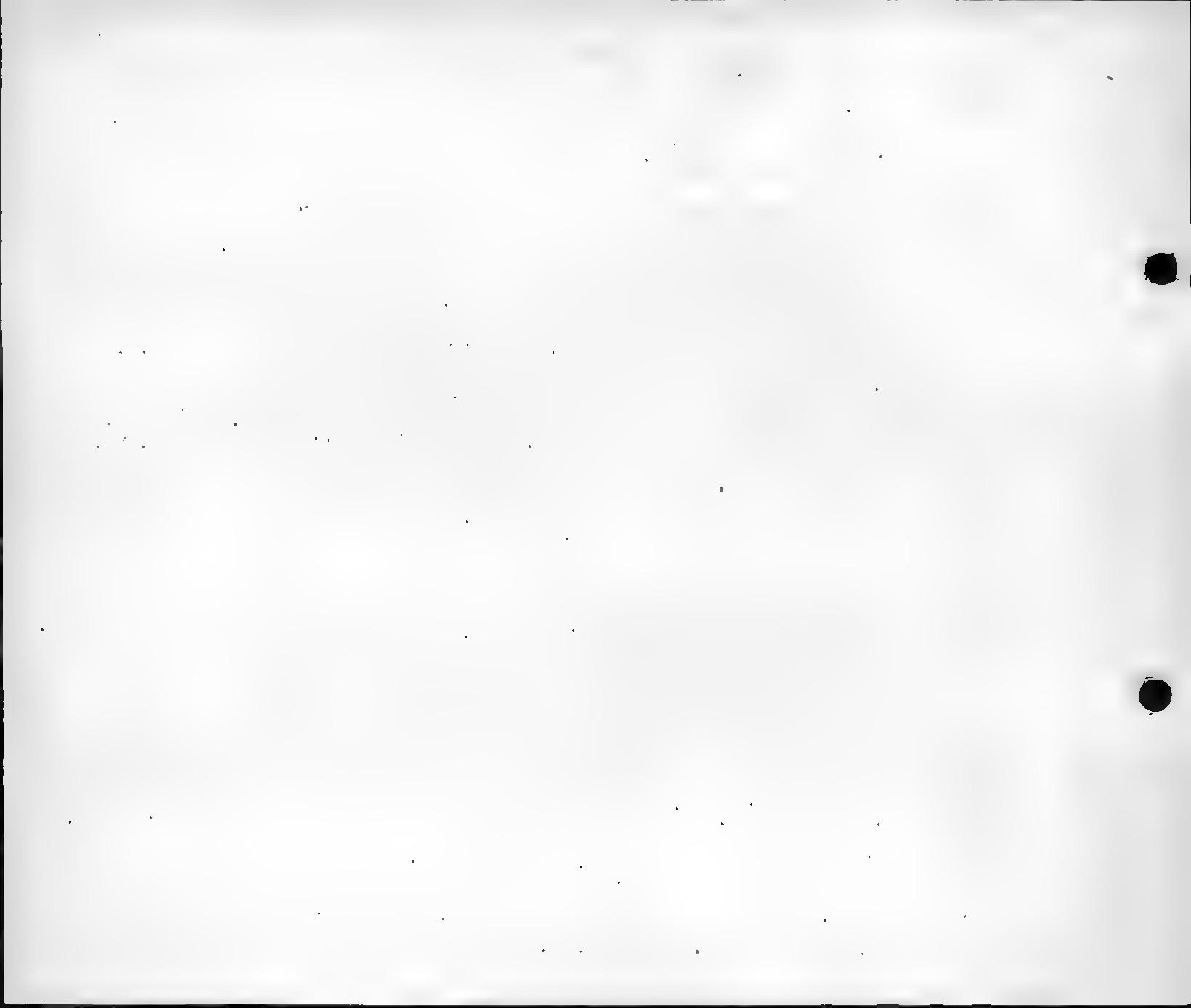
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|--|--|--|-----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase | | d. STREET ADDRESS 6904 Maple Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Jesse | Middle Hood | Last Davis | 4. DATE OF DEATH 2/17/60 | Month Day Year 19 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | b. DATE OF BIRTH 10/7/74 | 9. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad Engineer | | 11. BIRTHPLACE (State or foreign country) Arkansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Jefferson Davis | | 14. MOTHER'S MAIDEN NAME Martha Ann Hood | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. Unknown | INFORMANT Mrs DeMaris Davis Hearn | | 6004 Maple Ave. Chevy Chase, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 692.0 | | DUE TO (b) Acute Septicemia | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Severe cellulitis rt. face | | DUE TO (c) | | 10 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) (1) Arteriosclerosis General (2) Bronchiectasis, severe | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 3921 Ligonier St. N.W. | (County) Wash 15 D.C. | (State) Feb 17, 1960 | |
| 21. I certify that I attended the deceased from _____, 1957, to _____, 1960, that I last saw the deceased alive on _____, 1960, and that death occurred at 11:25 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Stewart Clapp PHYSICIAN'S NAME (Type) Robert A. Pumphrey | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/19/60 | 22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cem. | 22d. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR DATE FEB 23 '60 | 24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

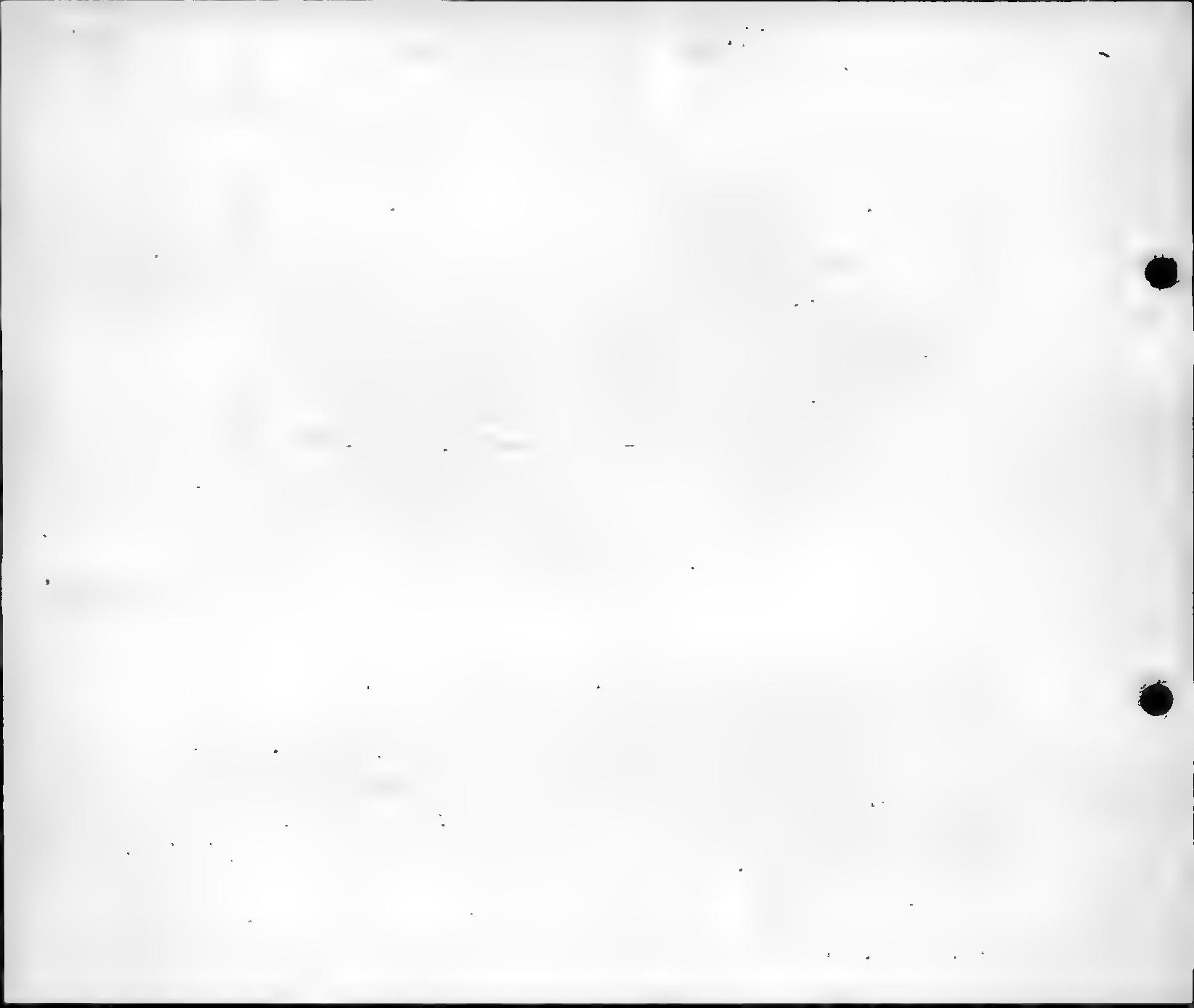
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2173 CERTIFICATE OF DEATH

02136

Reg. Dist. No.

| | | | | | | | |
|--|--|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. LENGTH OF STAY IN lb 32 years | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 S. Adams Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | | |
| 3. NAME OF DECEASED (Type or print) Walter Thomas Davis | | First Walter | Middle Thomas | | | | |
| 4. DATE OF DEATH February 10 | Month February | Day 10 | Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 28, 1881 | | | | |
| 9. AGE (In years last birthday) 78 | 10. IF UNDER 1 YEAR Months 9 | 11. IF UNDER 24 HRS Days 12 | 12. Hours 12 | | | | |
| 13. FATHER'S NAME George W. Davis | 14. MOTHER'S MAIDEN NAME Elizabeth Price | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | | 16. SOCIAL SECURITY NO 217-32-1885 | INFORMANT Mary S. Davis-Wife-same as 2d | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral hemorrhage, right hemiplegia | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) arteriosclerosis | | | | 5 years. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) No | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 110 S. Washington St |
| | | | | | | | (City or town) Rockville |
| | | | | | | | (County) Montgomery Co. |
| | | | | | | | (State) Md. |
| 21. I certify that I attended the deceased from 1930 , February 10, 1960 , that I last saw the deceased alive on February 9, 1960 , and that death occurred at 15 AM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wm. A. Linthicum ADDRESS (Street, city or town, state) 2/10/60. DATE SIGNED | | | | | | | |
| PHYSICIAN'S NAME (Type) William A. Linthicum | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/12/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery | 22d. LOCATION (City, town, or county) Rockville, Maryland | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR DATE FEB 11 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | | | |
| VS A1S (4) 15M 9/58 | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2169 CERTIFICATE OF DEATH

02137

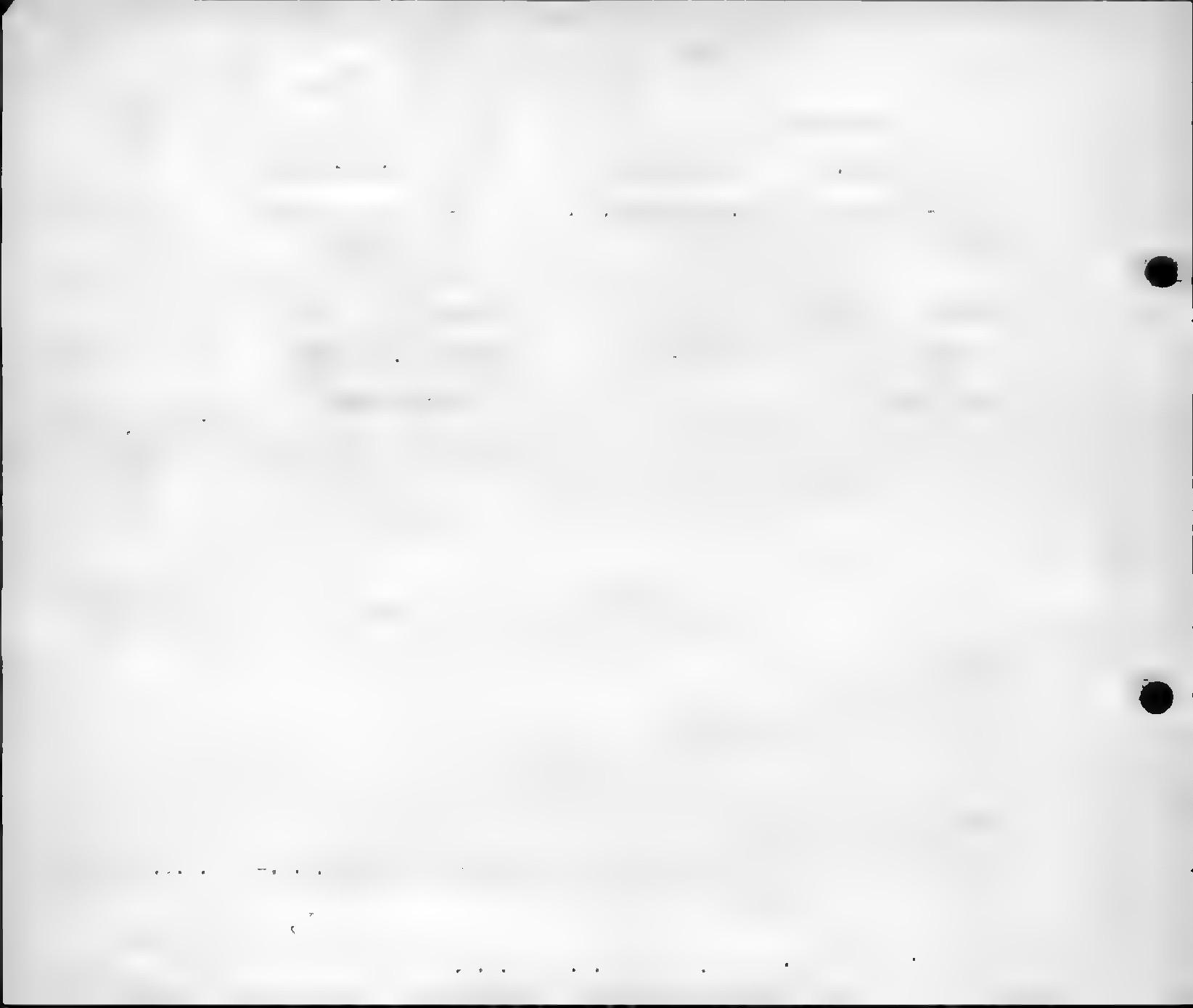
Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---------------------------------------|--|--|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD. | | c. LENGTH OF STAY IN b. 1 YEARS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MARYLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10018-FREDERICK AVENUE, KENSINGTON, MD. | | d. STREET ADDRESS 10018-FREDERICK AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>May</i> | Middle <i>Hastings</i> | Last <i>Dickinson</i> | 4. DATE OF DEATH February 14 1960 | Month February | Day 14 | Year 1960 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 10/19/1865 | 9. AGE (In years last birthday) 94 | 10. IF UNDER 1 YEAR Months 3 | 11. IF UNDER 24 HRS Days 26 | 12. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER | | 11. BIRTHPLACE (State or foreign country) MONTCLAIR, NEW JERSEY | | 12. CITIZEN OF WHAT COUNTRY UNITED STATES | |
| 13. FATHER'S NAME TYRUS CASS | | | | 14. MOTHER'S MAIDEN NAME MARY MILLARD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CATHERINE DICKINSON (NIECE) 10018-FREDERICK AVE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Hemorrhage DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Carcinoma of Colon (c) | |
| INTERVAL BETWEEN ONSET AND DEATH January | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 19, 1959 , to Feb. 14, 1960 , that I last saw the deceased alive on Feb. 13, 1960 , and that death occurred at 9:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>A. B. Little</i> | | ADDRESS (Street, city or town, state) 6911 5th St. NW Wash DC 2/14/60 | | | | | |
| PHYSICIAN'S NAME (Type) A. B. LITTLE, MD | | DATE SIGNED 2/14/60 | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/17/1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) (State) TROY, NEW YORK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO. | | ADDRESS 1500 N. STREET, N.W.—WASH. D.C. | | 24a. REC'D BY REGISTRAR FEB 17 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2138 CERTIFICATE OF DEATH

Reg. Dist. No.

02138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b 2½ yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 LEE AVENUE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | |
| 3. NAME OF DECEASED (Type or print) MARIE | | First P. | Middle DORSCH |
| 4. DATE OF DEATH FEB. 20 1960 | Month Day Year | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 6/25/73 |
| 8. WIDOWED <input type="checkbox"/> | 9. DIVORCED <input type="checkbox"/> | 9. AGE (In years lost birthday) 86 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHRISTIAN PFLIEGER | | 14. MOTHER'S MAIDEN NAME MARGUERITE SCHAFFERT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO NONE | |
| 17. INFORMANT Mr. Louis M. Dorsch, 15 Eastmoor Dr. Silver Spring, Maryland | | Address INTERVAL BETWEEN ONSET AND DEATH 1 YR. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 197. a. DUE TO PRIMARY SITE UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from alive on _____, and that death occurred at _____, 19_____, to _____, 19_____, that I last saw the deceased | | that death occurred at _____, 19_____, from the causes and on the date stated above. | |
| ACTUAL SIGNATURE DAVID GOLDENBERG M.D. | | ADDRESS (Street, city or town, state) 6727 16th ST. N.W. WASHINGTON, D.C. DATE SIGNED 2/20/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/23/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | |
| RAYMOND A. ZECKER | | 24a. REC'D BY REGISTRAR FEB 24 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE ARTHUR S. THOMAS | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

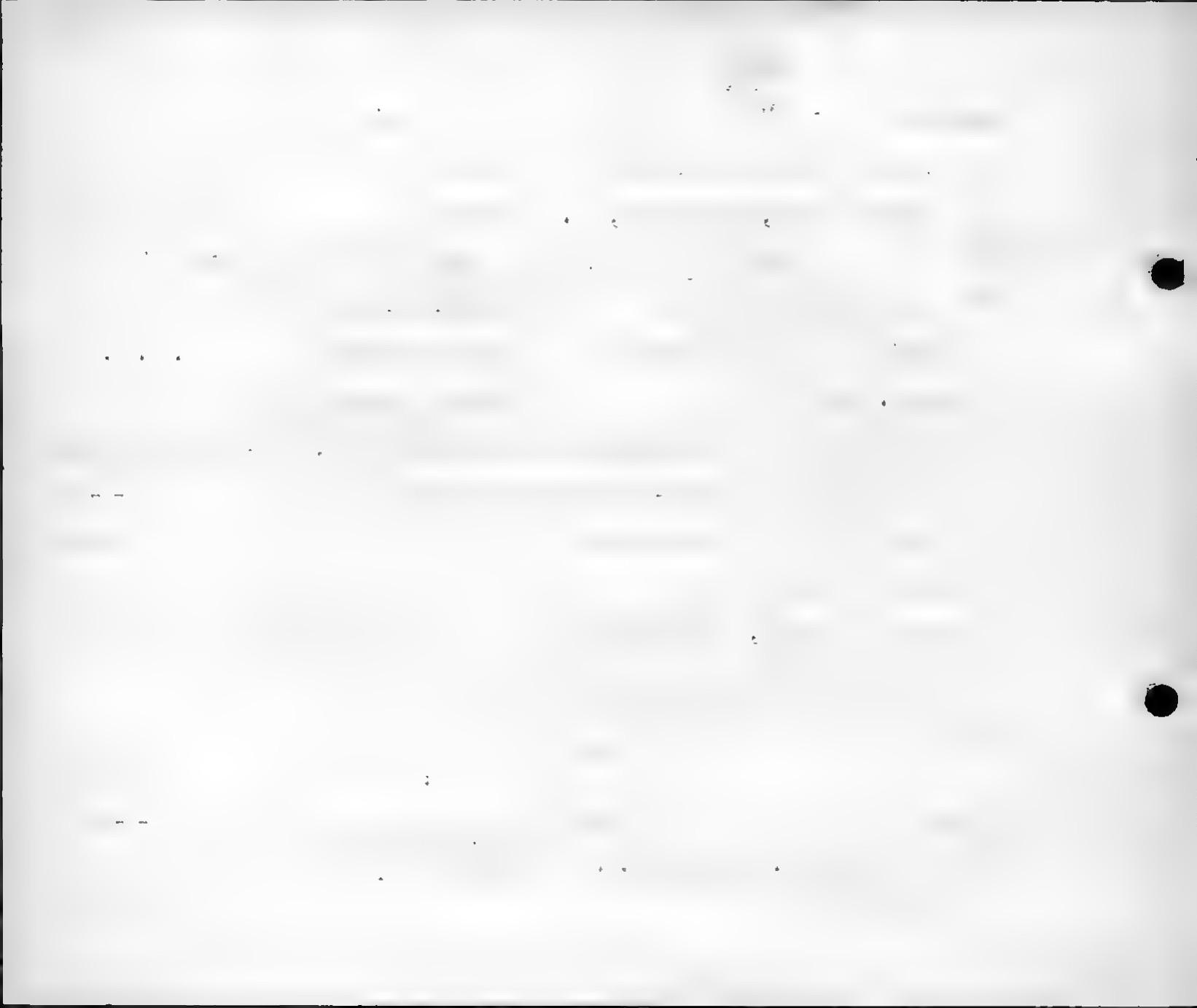
CERTIFICATE OF DEATH

02139

Reg. Dist. No

M

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 21 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marietta | |
| 3. NAME OF DECEASED (Type or print) Fred | | 4. DATE OF DEATH First Middle Last Month Day Year Henry Dunn February 7 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 6, 1902 | |
| 9. AGE (In years last birthday) 57 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | |
| 11. KIND OF BUSINESS OR INDUSTRY Trucking | | 12. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME William H. Dunn | | 14. MOTHER'S MAIDEN NAME Florence McGaha | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. Unascertainable | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) Gastro-Intestinal Hemorrhage DUE TO Stomach Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) | |
| | | INTERVAL BETWEEN ONSET AND DEATH 1-2-days | |
| 19. MEDICAL CERTIFICATION Pulmonary Infarcts, Aortic Stenosis | | 20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 17, 1960 , to February 7, 1960 that I last saw the deceased alive on February 7, 1960 , and that death occurred at 10:35A , from the causes and on the date stated above. ACTUAL SIGNATURE Charles A. Chidsey | | ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland DATE SIGNED 2-7-60 | |
| PHYSICIAN'S NAME (Type) CHARLES A. CHIDSEY, M.D. | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 22b. DATE THEREOF 2/17/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 5100 3rd Street NW | |
| 22d. LOCATION (City, town, or county) Glenmont | | 24a. REC'D BY REGISTRAR DATE FEB 10 '60 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Chidsey | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2202

CERTIFICATE OF DEATH

Reg. Dist. No.

02140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this cert. form has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death

Page 4

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b I 1 days | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| 3. NAME OF DECEASED (Type or print) Kathryn Smoot | | First Kathryn | Middle Smoot |
| | | Last DuQuoin | 4. DATE OF DEATH February 19 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH December 14, 1884 |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (in years last birthday) 75 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf. | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaker | |
| 10c. BIRTHPLACE (State or foreign country) Illinois | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John M. Smoot | | 14. MOTHER'S MAIDEN NAME Minnie Brooks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT yes-Unknown John S. DuQuoin (son) same as above #2d | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 480X Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 2 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Influenza | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| DUE TO Influenza | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| DUE TO Influenza | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 9, 1961 to Feb 19, 1961 , that I last saw the deceased alive on 2/19/61 , 19, and that death occurred at 8:15 AM , from the causes and on the date stated above | | ADDRESS (Street, city or town, state) 6450 Wisc. Ave., Bethesda, Md. | |
| ACTUAL SIGNATURE Dr. Joseph Kenrick | | DATE SIGNED 2/19/61 | |
| PHYSICIAN'S NAME (Type) Dr. JOSEPH KENRICK | | M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/22/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE FEB 24 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knapp | |



18
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
 a. COUNTY MONTGOMERY MARYLAND
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
 c. LENGTH OF STAY IN 1b
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
 5073 SMITH COURT

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
 a. STATE MARYLAND
 b. COUNTY MONTGOMERY
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
 d. STREET ADDRESS
 5073 SMITH COURT

e. IS RESIDENCE ON A FARM?
 YES NO

3. NAME OF DECEASED (Type or print) JOHN H. DYSON First M dd e Last Month Day Year
 4. DATE OF DEATH FEBRUARY 29 1960

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH JUNE 4, 1897
 MALE COL. WIDOWED DIVORCED

9. AGE (in years last b. ~~42~~ 42 months d. Days Hours Min.)
 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPT. GARAGE 10b. KIND OF BUSINESS OR INDUSTRY AUTO 11. BIRTHPLACE (State or foreign country) D. C.
 13. FATHER'S NAME JOHN H. DYSON 14. MOTHER'S MAIDEN NAME SOPHIE MATTHEWS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
 (Yes, no, or unknown) (If yes, give rank or date of service) Katherine Dyson Address 5000 River Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION
 420.1 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
 DUE TO
 (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY PERFORMED?
 YES NO

20c. TIME OF INJURY Month, Day, Year
 Hour a.m. While at work Not While at work
 p.m. While at work Not While at work
 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town)
 (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE *Frank J. Broschart* CHIEF MEDICAL EXAMINER
 EXAMINER'S NAME (Type) FRANK J. BROSCHEART ASSISTANT MEDICAL EXAMINER
 22e. BURIAL, CREMATION, REMOVAL (Specify) 22f. DATE THEREOF 22g. NAME OF CEMETERY OR CREMATORIUM 22h. LOCATION (City, town, or country)
 Burial 3/3/60 Lincoln Memorial Suitland, Maryland
 (State) (State)

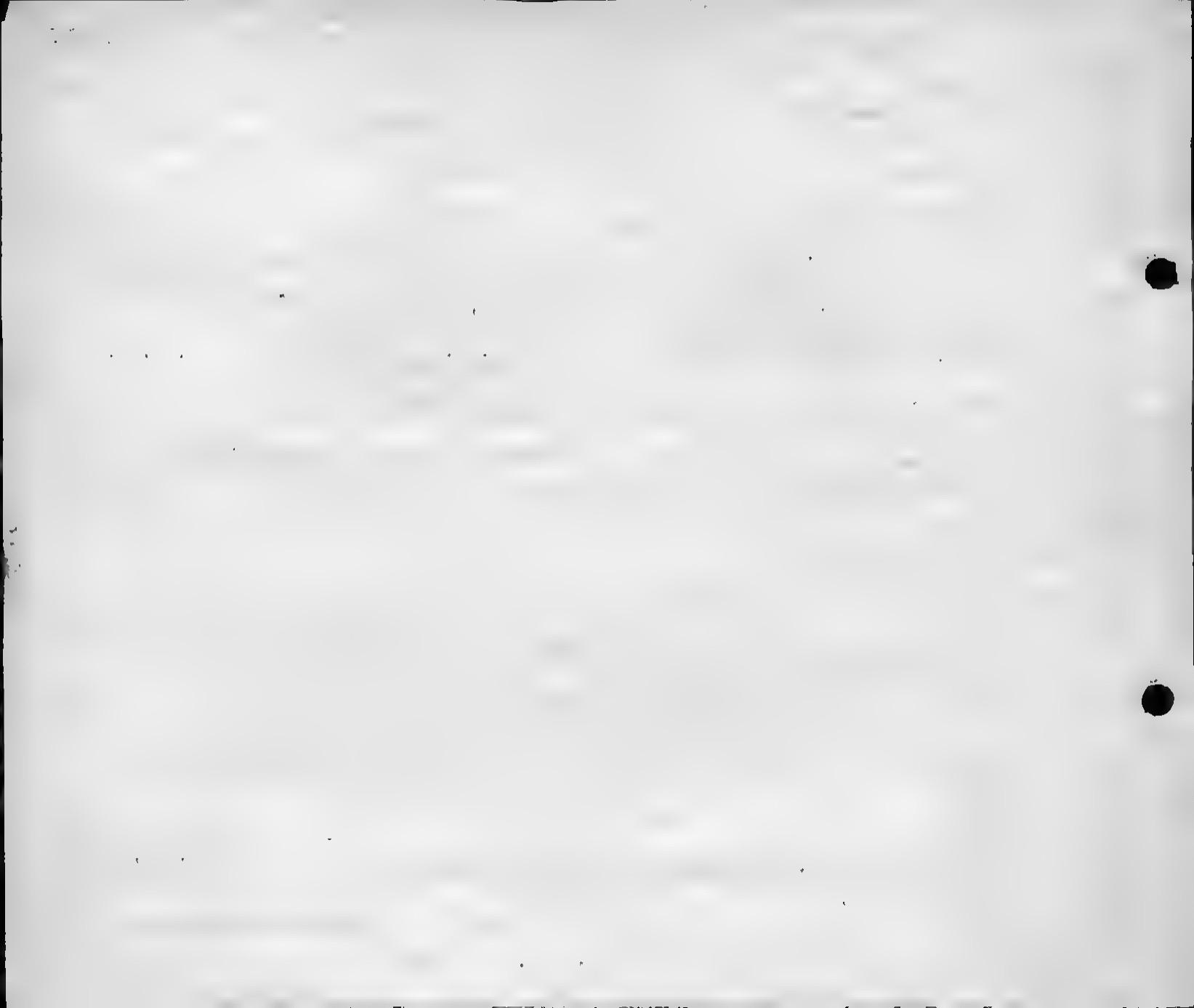
22i. FUNERAL DIRECTOR ADDRESS 24e. REC'D BY REGISTRAR 24f. REGISTRAR'S SIGNATURE
 30 H Street, N.E. MAR 3 '60 *Charles S. Krueger*

VS. A15ME
 5M 7/59

INTERVAL BETWEEN ONSET AND DEATH
 SUDDEN

MEDICAL CERTIFICATION

DATE SIGNED
 FEB. 29, 1960



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2204 CERTIFICATE OF DEATH

Reg. Dist. No. 215

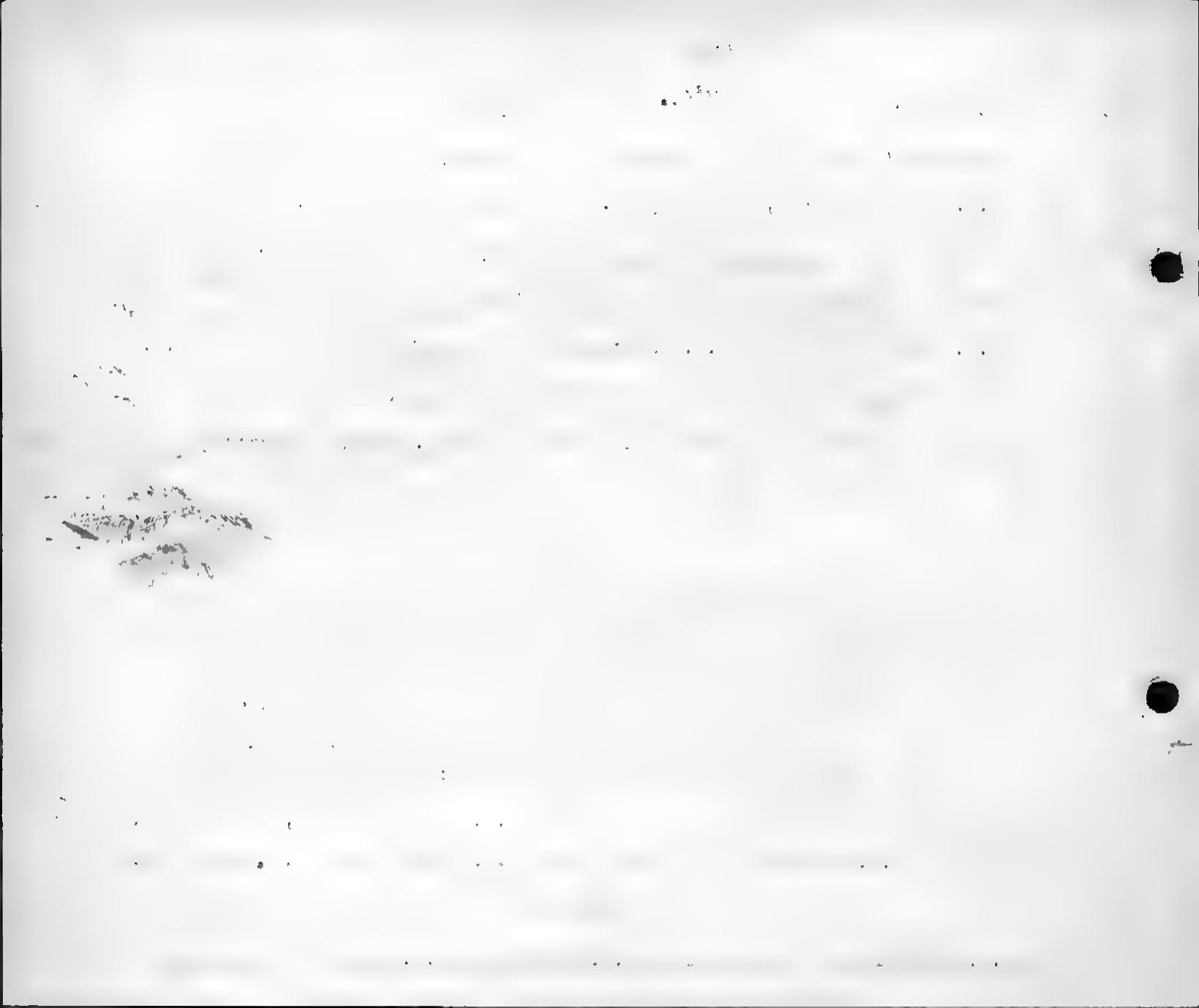
02142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
TSM 9/58

| | | | | | |
|---|----------------------------------|---|------------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) STATE Florida | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 5 days | | b. COUNTY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville | |
| 3. NAME OF DECEASED (Type or print) Harould Loyd ELDER | | First | Middle | Lost | 4 DATE OF DEATH Month February 24 Year 1960 |
| S. SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 9-30-22 | 9. AGE (In years, last birthday) 37 yrs. | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | |
| 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Wyach ELDER | |
| 14. MOTHER'S MAIDEN NAME Ina FULLER | | 15. INFORMANT (Wife) Vera I. ELDER | | Address Same as #2 | |
| 16. SOCIAL SECURITY NO 418 36 3117 | | 17. IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO Brain tumor (metastatic) INTERVAL BETWEEN ONSET AND DEATH 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Carcinoma lung. 1 month (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 February, 1960 , to 24 February, 1960 , that I last saw the deceased alive on 24 February, 1960 , and that death occurred at 8:50A M , from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) W.H. Druckemiller, M.D. U.S. Naval Hospital, Bethesda Md. 2-25-60 | | | | | |
| DATE SIGNED | | | | | |
| ACTUAL SIGNATURE W.H. Druckemiller | | | | | |
| PHYSICIAN'S NAME (Type) W.H. DRUCKEMILLER CAPT MC USN U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/25/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Dover Cemetery | |
| 22d. LOCATION (City, town, or county) Dover | | | | (State) Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamber | | ADDRESS 1400 Chapin Street N.W. Washington | | 24a. REC'D BY REGISTRAR Dr C FEB 29 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Cather & Thomas | |



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2205 CERTIFICATE OF DEATH

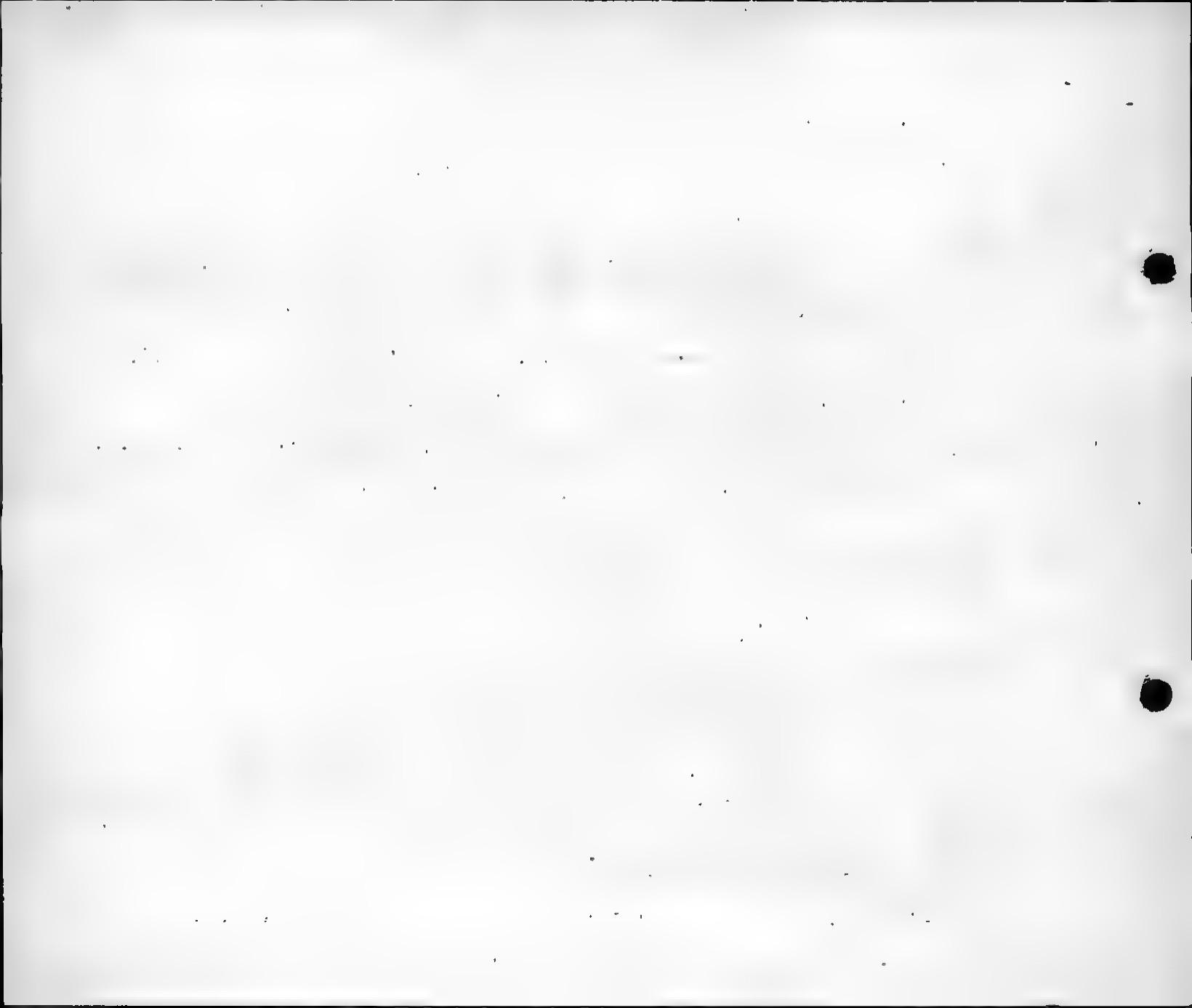
02143

Reg. Dist. No.

| | | | | | |
|--|--|--|---|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| Montgomery | | | | a. STATE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | Maryland | |
| Bethesda | | 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Suburban | | | | Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | |
| Charles Willis Embrey | | | | Norton & South Glen Road | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH | Feb. 20 1960 |
| Male | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 4/17/17 | 9 AGE (in years lost birthday) 42 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Virginia | |
| Cab Dispatcher | | Bethesda Cab Co. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Halto W. Embrey | | Ruth Emma May Simpson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | | INFORMANT Address | |
| No | | 213-12-1955 | | Sister Mrs. Weaver Purcellville, Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brunchus pneumonia, b. lateral</u> | | | | | |
| 491X DUE TO | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | | | | |
| DUE TO | | | | | |
| (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | |
| Severe fatty degeneration liver | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 19 | | | | 20. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 16, 1960, to Feb 20, 1960, that I last saw the deceased alive on Feb 19, 1960, and that death occurred at 5:45 AM, from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE <u>Edward S. Witowski Jr. M.D.</u> Suite 400, 8218 Wisconsin Ave., Bethesda 14, Maryland. 2/20/60 | | | | | |
| PHYSICIAN'S NAME (Type) | | 22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF | | | |
| Burial | | 22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Cemetery | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 22d. LOCATION (City, town, or county) (State) Round Hill, Virginia | | | |
| Robert A. Pumphrey Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE FEB 24 '60 | | | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

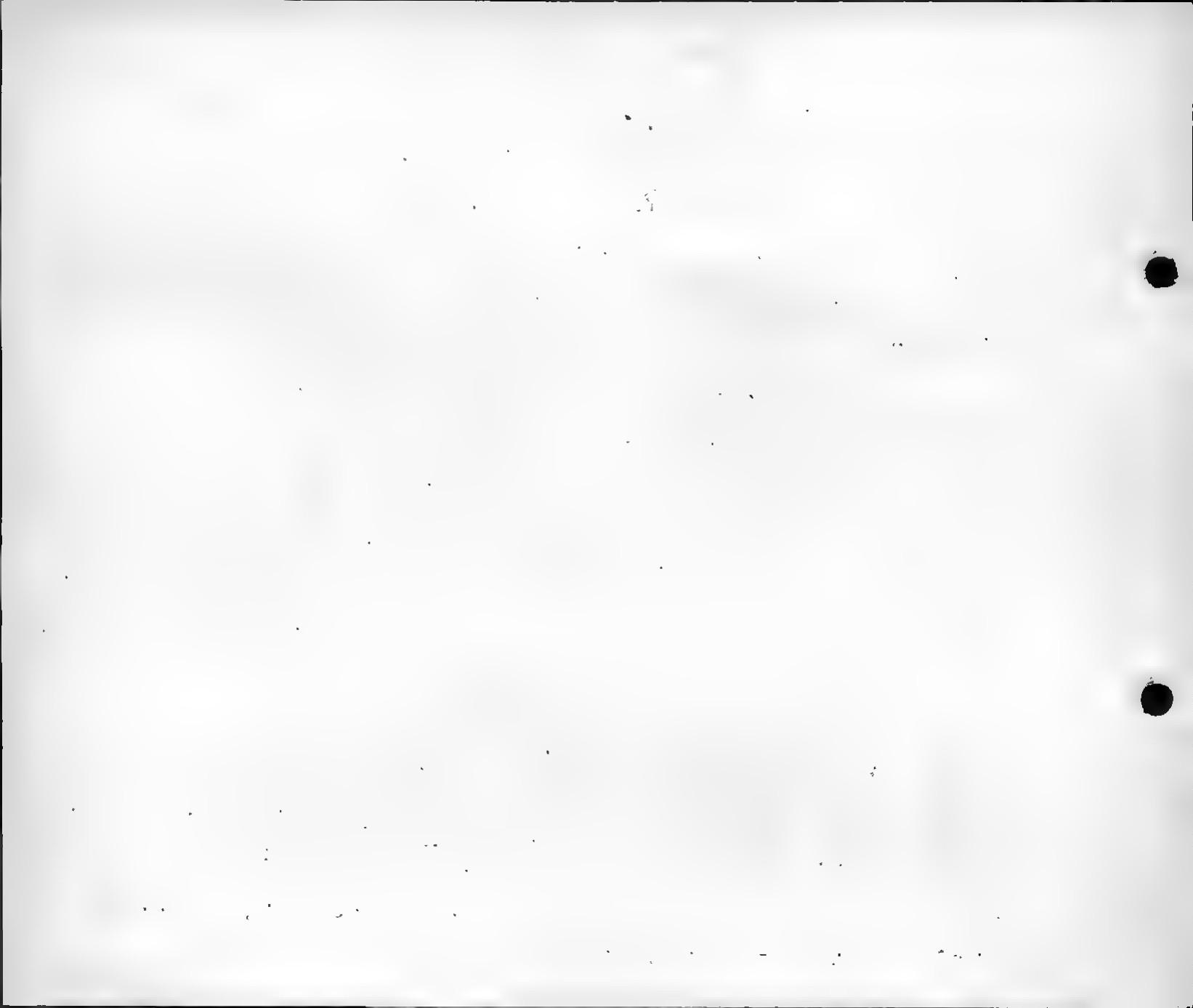
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2206 CERTIFICATE OF DEATH

02144

Reg. Dist. No.

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | 8 MONTHS | | d. STATE MARYLAND b. COUNTY MONTGOMERY | |
| c. LENGTH OF STAY IN 1b | | BETHESDA 57 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 6307 TULSA LANE | | d. STREET ADDRESS 6307 TULSA LANE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First ELMER | Middle LINWOOD | Last EVANS | 4. DATE OF DEATH FEBRUARY 12 1960 |
| 5. SEX MALE | | 6. COLOR OR RACE CAUCASOID | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 19 1883 | 9. AGE (In years lost birthday) 76 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY LIGHTING FIXTURES | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME ROBERT G. EVANS | | 14. MOTHER'S MAIDEN NAME EMMA CATLIN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No. | | 16. SOCIAL SECURITY NO. 578-09-5986 MRS. EVANS | | INFORMANT Address 6307 TULSA LANE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | CONGESTIVE HEART FAILURE 1 WEEK | | | |
| 45.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 3 YEARS | | | |
| (b) DUE TO | | GENERALIZED ARTERIOSCLEROSIS 15 YEARS | | | |
| (c) DUE TO | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| INANITION; INFLUENZA-LIKE ILLNESS BEGAN FEB. 4, 1960 | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB. 4, 1960, to FEB. 12, 1960, that I last saw the deceased alive on FEB. 10, 1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) 9420 Old Georgetown Rd 2/12/60 DATE SIGNED 2/12/60 | | | |
| ACTUAL SIGNATURE Joseph D. Connor, M.D. | | 22. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | | |
| PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR, M.D. | | 22b. DATE THEREOF 2/15/1960 | | | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery | | 22d. LOCATION (City, town, or county) Rockville, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland | | 24a. RECEIVED BY REGISTRAR FEB 15 1960 DATE | | | |
| | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

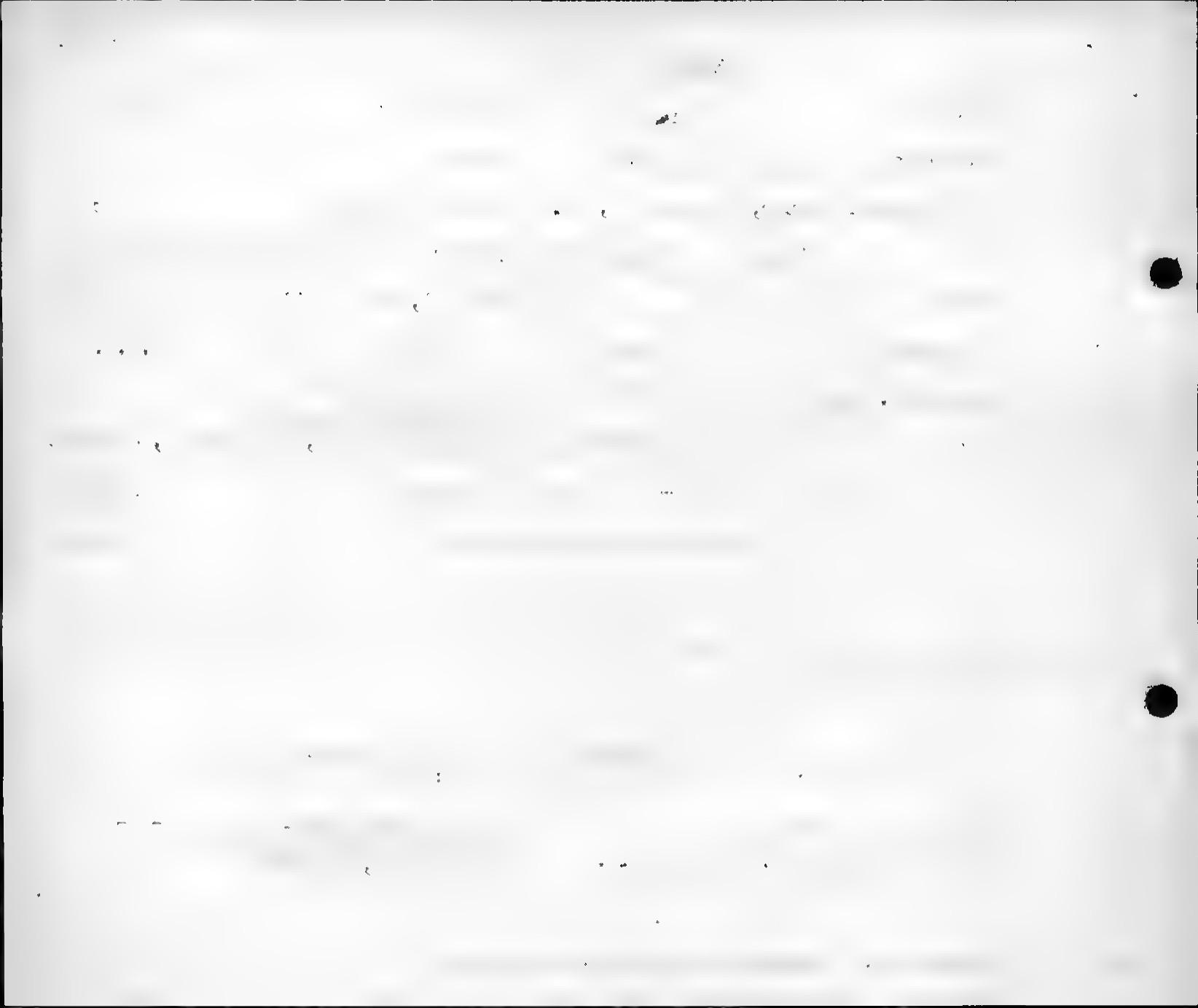
02145

CERTIFICATE OF DEATH

Reg. Dist. No.

2207

| | | | | | | | |
|--|----------------------------------|--|---|---|--|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE West Virginia | | b. COUNTY Hampshire | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN TB 54 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney | | d. STREET ADDRESS No street address | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Viola | Middle Virginia | Last Feller | 4. DATE OF DEATH February 19, 1960 | Month February | Day 19 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH October 11, 1928 | 9. AGE (In years lost birthday) 31 yrs. | IF UNDER 1 YEAR Months 31 | IF UNDER 24 HRS. Days 0 | Hours 0 |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Indian O. Sword | | 14. MOTHER'S MAIDEN NAME Ethel Kessel | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 27, 1959 , to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 8:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 2-19-60 | | | | | | | |
| ACTUAL SIGNATURE Charles E. Mengel | | M.D. Charles E. Mengel, M.D. National Institutes of Health Bethesda 14, Maryland | | | | | |
| PHYSICIAN'S NAME (Type) CHARLES E. MENGEGL, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/22/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery | | 22d. LOCATION (City, town, or county) West Virginia Hampshire (State) CO. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey | | ADDRESS Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File # 73-1-6 e

2208

CERTIFICATE OF DEATH

Reg. Dist. No.

02146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this cert'ficate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bus. air-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of her death.

| | | | | | | | | |
|---|------------------------------------|---|--------------------------------------|---|--|---|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville | | c. LENGTH OF STAY IN 1b life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville, | | d. STREET ADDRESS / | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First JOHN | Middle AUGUSTA | Last FISHER | 4. DATE OF DEATH Month Feb. Day 7 Year 1960 | Month Feb. | Day 7 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 1870/1871 | 9. AGE (In years last birthday) 88 yrs | 10. CITIZEN OF WHAT COUNTRY? Maryland | | 11. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 12. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. U. S. A. | |
| 10a. USA. OCCUPATION (Give kind of work done during most of working life, even if retired) Leborer | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland | | | | | | |
| 13. FATHER'S NAME John A. Fisher | | 14. MOTHER'S MAIDEN NAME Ellen Alice Washington | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | INFORMANT William R. Hood | | Address Beallsville, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x Due to Hypoxia | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Renal Arteriosclerosis Due to (c) Generalized Arteriosclerosis | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 4 Feb 1 1960 to 7 Feb 1 1960 , that I last saw the deceased alive on 6 February 1960 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE John W. Smiths | | ADDRESS (Street, city or town state) Barnesville, Md. | | | | | | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 11 Feb 60 | | | | | | |
| 22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/11/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion, | | 22d. LOCATION (City, town, or county) (State) Barnesville, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Scudder | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 24 1960 | | 24b. REGISTRAR'S SIGNATURE John S. Kline | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, 8, 14 File G227 3-1-60 et
2209 CERTIFICATE OF DEATH

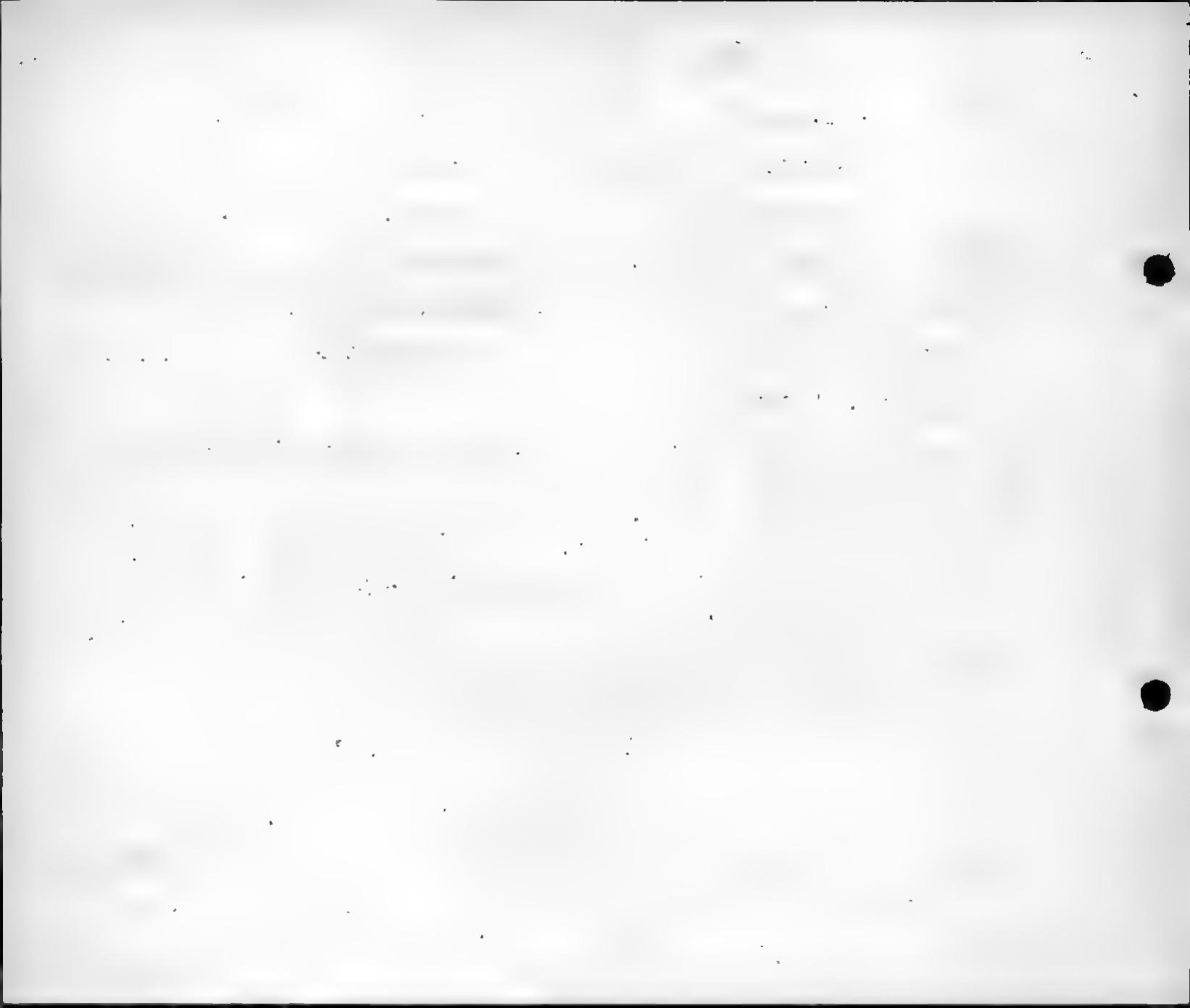
Reg. Dist. No.

02147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. LENGTH OF STAY IN 1b 17 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First IRENE | Middle VIRGINIA | Last FRAZIER |
| 4. DATE OF DEATH 2 23 1960 | Month | Day | Year |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8 1909 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY / 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 13. FATHER'S NAME WILLIAM R. O'DANIEL | | 14. MOTHER'S MAIDEN NAME Unknown Nutie Goodwin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO None | INFORMANT HUSBAND |
| | | Address CHARLES WESLEY FRAZIER | |
| 18. CAUSE OF DEATH [Enter only one cause per line on (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Peritonitis | | | |
| DUE TO (b) Abdominal carcinomatosis DUE TO (c) Recurrent carcinoma of liver after peritoneal 2 years | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 week | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July , 1958, to Feb 23 , 1960, that I last saw the deceased alive on Feb 23 , 1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE John C. Murphy | | ADDRESS (Street, city or town, state) M.D. 1501 EYE ST NW Washington, D.C. | |
| PHYSICIAN'S NAME (Type) JOHN C. MURPHY, | | DATE SIGNED 2-24-60 | |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF Burial transit 2-24-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Montlawn Cemetery | 22d. LOCATION (City, town, or county) (State) Wake County, North Car. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Murphy Funeral Home | | 24a. REC'D BY REGISTRAR Arthur L. Tracy | 24b. REGISTRAR'S SIGNATURE Arthur L. Tracy |
| | | DATE FEB 26 '60 | |



X 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If more time is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2119 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02148

Reg. Dist. No.

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN lb DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SEMINARY ROAD AND SUTTON PLACE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON | | | |
| d. STREET ADDRESS 7710 EASTERN AVE. N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MOE | | First FREIDIN | Middle | | |
| 4. DATE OF DEATH Feb. 15 1960 | Month Feb. | Doy 15 | Year 1960 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/15/1902 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY HECKMAN PRODUCTS | | | |
| 11. BIRTHPLACE (State or foreign country) NEW YORK | | 9. AGE (In years last birthday) 57 yrs. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ABRAHAM FREIDIN | 14. MOTHER'S MAIDEN NAME BERTHA UNKNOWN | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | 17. INFORMANT Mrs. Frances C. Freidin, 7710 Eastern Ave., NW Washington, D.C. | | | |
| Address INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2/15/60 | | |
| EXAMINER'S NAME (Type) FRANK J. BROSCHEART | 22a. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-16-60 | 22c. NAME OF CEMETERY OR Crematory KING DAVID MEM. GARDEN | 22d. LOCATION (City, town, or county) FALLS CHURCH VA. |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS | ADDRESS 3501-14th St. NW | | 24a. REC'D BY REGISTRAR DATE FEB 18 '60 | 24b. REGISTRAR'S SIGNATURE Charles S. Francis | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02149

2210

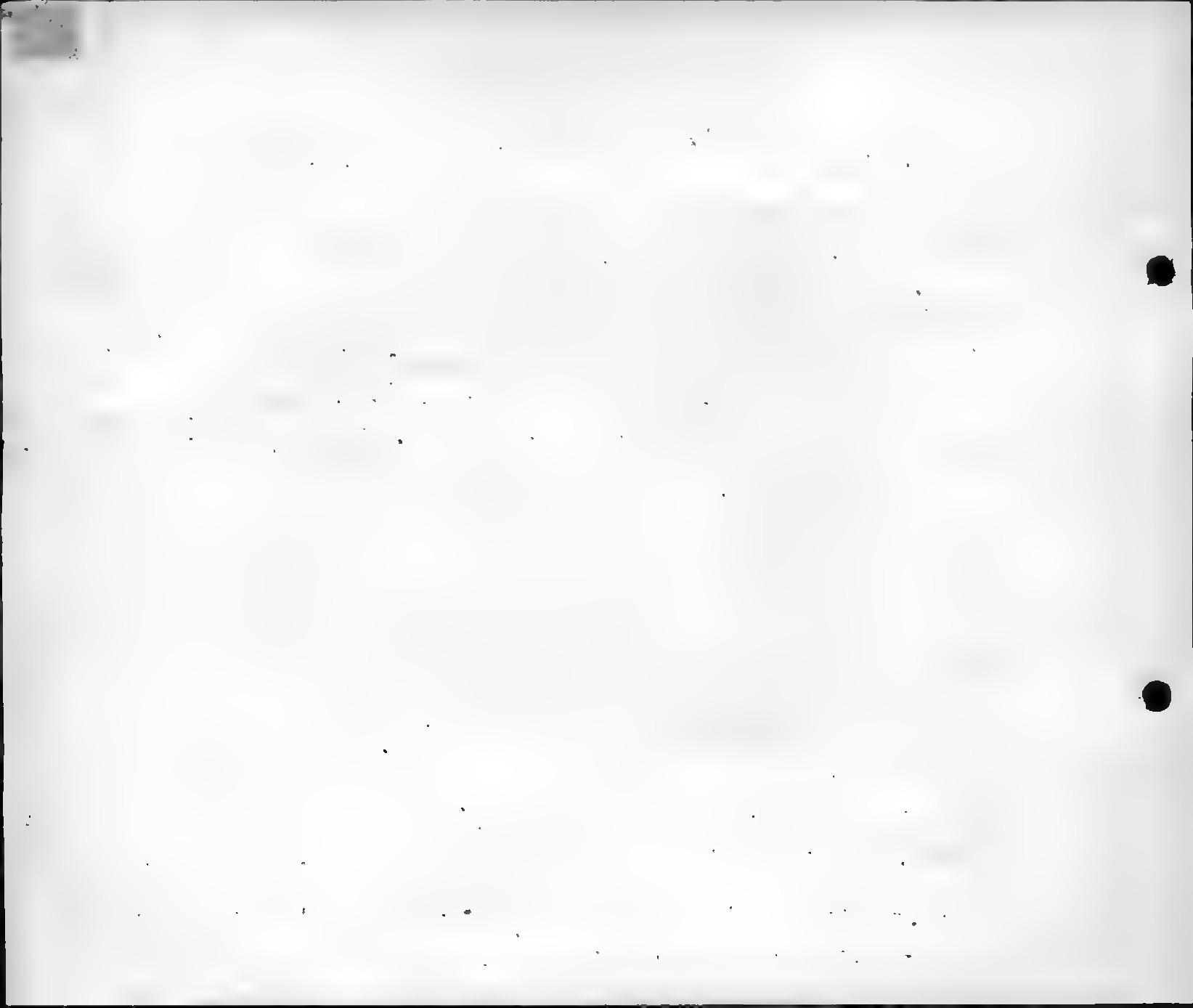
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DEPTHSNA - DOA</i> | | c. LENGTH OF STAY IN 1b <i>DOA</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN HOSPITAL</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) | First <i>Mary</i> | Middle <i>Margaret</i> | Last <i>Gallagher</i> |
| 4. DATE OF DEATH | Month <i>2</i> | Day <i>6</i> | Year <i>1960</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/7/87</i> |
| 9. AGE (In years last birthday) <i>72 yrs</i> | 10. US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>HOMEMAKING</i> | 12. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i> |
| 13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 14. FATHER'S NAME <i>Kohlman, Fred</i> | 15. MOTHER'S MAIDEN NAME <i>Annie Hever</i> | 16. SOCIAL SECURITY NO <i>none</i> |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i> | 18. INFORMANT <i>Walter W. Gallagher</i> | 19. ADDRESS <i>10106 Herford Place</i> | 20. INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>443X</i> | | DUE TO <i>Hypertension heart disease</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> | | DUE TO (c) <i></i> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Feb 6, 1960</i> to <i>Feb 6, 1960</i> , that I last saw the deceased alive on <i>Feb 6, 1960</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>J.R. Tammie</i> | M.D. <i>S. L. Tammie, M.D.</i> | ADDRESS (Street, city or town, state) <i>SILVER SPRING MARYLAND</i> | DATE SIGNED <i>2-6-60</i> |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2-9-60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>77th Avenue Cemetery Prince Georges Md.</i> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins 3821-14th St. N.W. DC.</i> | ADDRESS <i>Wash.</i> | 24a. REC'D BY REGISTRAR DATE <i>FEB 8 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>C. Clark, Clerk</i> |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

U2150

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

2119

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN TB

1 mo.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Fairland Nursing Home

3. NAME OF
DECEASED
(Type or print)

Julius

First

Middle

Gertler

Last

4. DATE
OF
DEATH

Feb

Month

25

Day

19

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

1-10-1880

9. AGE (In years
last birthday) yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tanner (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY

Nursing Home Record

11. BIRTHPLACE (State or foreign country)

To Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(b)

DUE TO
(c)

myocardial Infarct

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

2 mo

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g.

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

FRANK J. Broschart

22a. BURIAL, CREMATION
REMOVAL (Specify)

BURIAL 7/26/60

22b. DATE THEREOF

7/26/60

22c. NAME OF CEMETERY OR CREMATORIUM

BNAI ISRAEL

Cem OXON HILL MD

22d. LOCATION (City, town, or country)

MD

24a. REC'D BY REGISTRAR

DATE FEB 29 '60

24b. REGISTRAR'S SIGNATURE

Albert S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

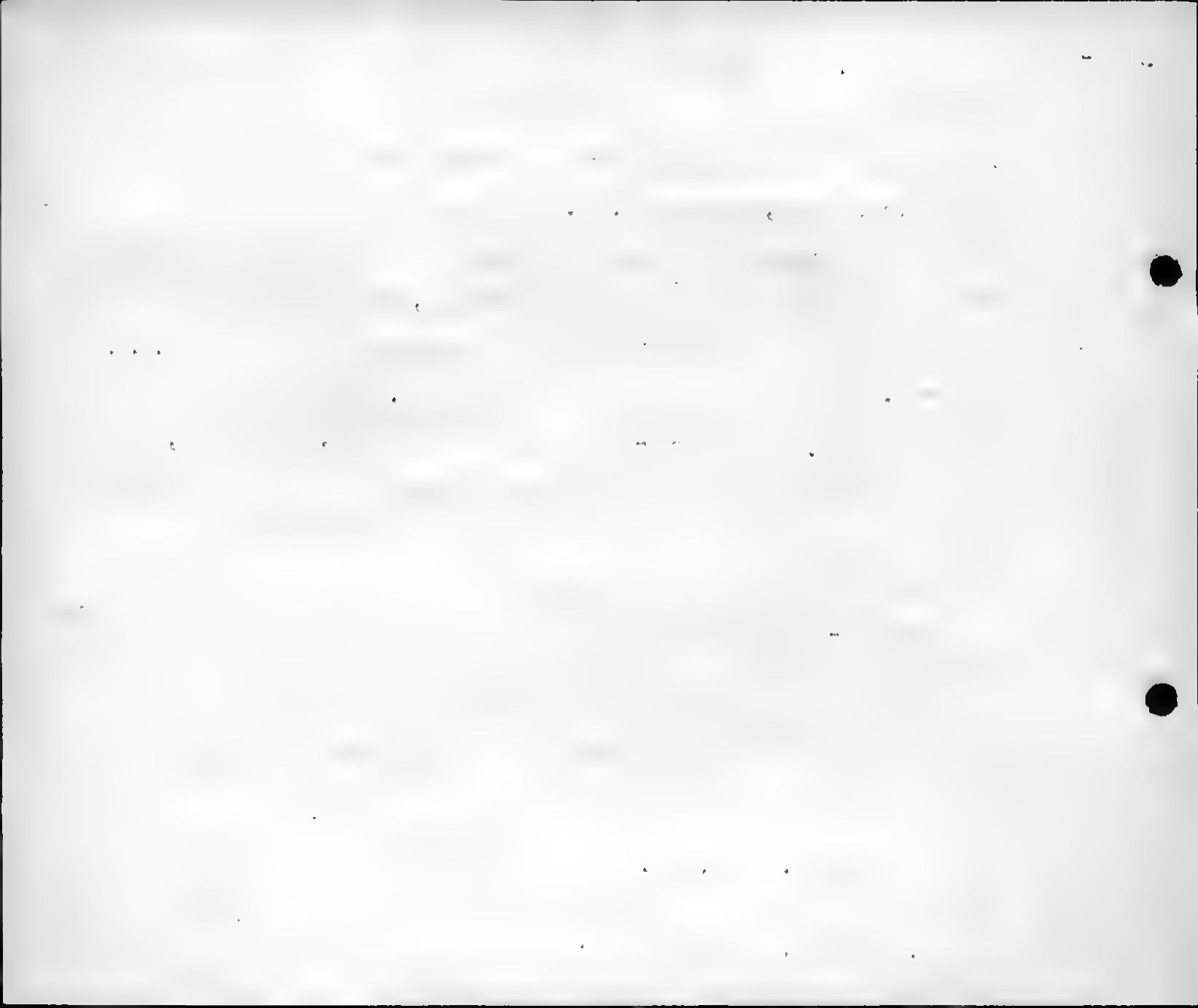
02151

2211

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--|--|--|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Michigan | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 111 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grosse Pointe | | d. STREET ADDRESS 991 South Oxford Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Norman | Middle Glyde | Last Geyer | 4. DATE OF DEATH | Month February | Day 28 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 11, 1892 | 9. AGE (In years last birthday) 67 yrs | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Products | | 11. BIRTHPLACE (State or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William F. Geyer | | 14. MOTHER'S MAIDEN NAME Margaret A. Blakely | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO WW 1 | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 229X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | Malignant carcinoid syndrome | | INTERVAL BETWEEN ONSET AND DEATH years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Broncho-pneumonia | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from November 9, 1959 to February 28, 1960 , that I last saw the deceased alive on February 28, 1960 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. | ADDRESS (Street, city or town, state) | | | | DATE SIGNED 2/29/60 | | |
| ACTUAL SIGNATURE <i>Victor W. Sidel</i> | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | |
| PHYSICIAN'S NAME (Type) Victor W. Sidel, M.D. | | | | | | | |
| 22a. BURIAL, CREMAT. ON REMOVAL (Specify) burial | 22b. DATE THEREOF 2/29/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Forrestlawn Cemetery | 22d. LOCATION (City, town, or county) Detroit, Michigan | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | ADDRESS 2901 14th St. N.W. | 24a. REC'D BY REGISTRAR DATE MAR 1 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | | |



02152

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to removal.

Item 18 Film 25
3-10-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| 2212 Montgomery Maryland | | a. STATE Md b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda DCA | | c. LENGTH OF STAY IN 1B Suburban | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS Poolsville | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| Peggy Janet Gibson | | Last | |
| 4. DATE OF DEATH | | Month | Day |
| Feb 19 1960 | | Year | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| F | | W | 8. DATE OF BIRTH Jan 20 1960 |
| 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR Months 0 Days 29 Hours 0 Min. 0 | |
| yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Singer | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Bethesda Md | |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Ronald Gibson | | 14. MOTHER'S MAIDEN NAME Mildred Keen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Mother Sane as item 2 | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501X DUE TO Pulmonary edema, marked Conditions, if any, which gave rise to immediate cause (b) Focal hemorrhages, pulmonary parenchymal & plural if any, stating the underlying cause lost. DUE TO Mesenteric lymphadenitis (c) Visceral congestion, marked | | Sudien death | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Borschart</i> | | DATE SIGNED 2-19-60 | |
| EXAMINER'S NAME (Type) <i>FRANK J. Borschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb 19 60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL The cemetery | | 22d. LOCATION (City, town, or county) Lanham, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William R. Hilton, Pa. will hilton | | ADDRESS | |
| 24a. REC'D BY REGISTRAR FEB 24 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5 & 7 File #250 2/11/60 iwk

02153

CERTIFICATE OF DEATH

Reg. Dist. No.

2213

1. PLACE OF DEATH
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

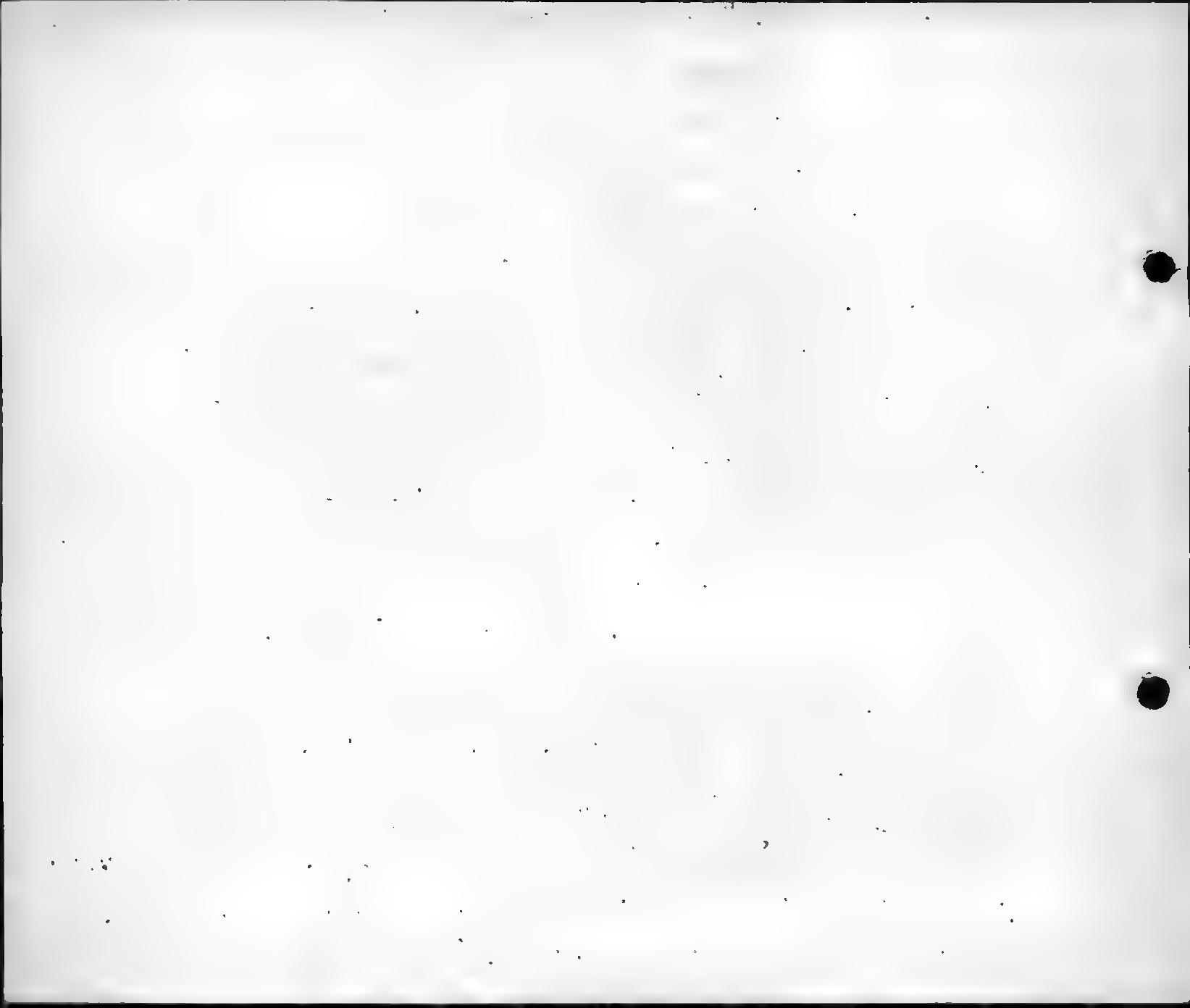
Bealeton

RURAL

2 boro 25 m

Tuckahoe

Md.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2214

CERTIFICATE OF DEATH

02154

| | | | | | | | |
|---|----------------------------------|--|--|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 16 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Sanitarium | | d. STREET ADDRESS 1801 E. Montgomery Ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Lillian | Middle Aleta | Last Graham | 4. DATE OF DEATH February 9 19 60 | Month Day Year | | |
| S SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B DATE OF BIRTH May 11, 1872 | 9 AGE (In years from birthday) 87 yrs | 10 IF UNDER 1 YEAR Months Days | 11 IF UNDER 24 HRS Hours Min | |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Andrew J. Ferguson | | 14. MOTHER'S MAIDEN NAME Famantha Whims | | Address | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Mrs. James H. Taylor-daughter-same 2d | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332 X DUE TO <i>Cerebral Embolism</i> INTERVAL BETWEEN ONSET AND DEATH 3 HRS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO <i>Generalized ARTERIOSCLEROSIS</i> AGE 76 | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>See 1950 to Feb 1960, that (I) (we) last saw the deceased alive on Feb 1960 and that death occurred at 12 noon</i> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>See</i> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19____, that (I) (we) last saw the deceased alive on _____ and that death occurred at _____ M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Dr. Leo I. Donovan</i> | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 2/10/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Leo I. Donovan, M.D. | | 22d. ADDRESS <i>601 Georgetown Road Bethesda Md.</i> | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/13/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery | | 23d. LOCATION (City, town or county) (State) Prince George Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR DATE FEB 11 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Clinton S. Knapp</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2215

CERTIFICATE OF DEATH

Reg. Dist. No.

02155

| | | | |
|--|--|--|---------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | |
| Montgomery MARYLAND | | Maryland Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RDI, Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home, RDI, Silver Spring | | d. STREET ADDRESS Lindan | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Sarah | Middle ANN |
| 4. DATE OF DEATH | | Month 2 | Day 12 |
| 5. SEX | | Year 1960 | |
| Female Negro | | 6. COLOR OR RACE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1872 | |
| 9. AGE (In years last birthday) 88 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Daniel Lewis, Nephew | | Address 816 Colby Ave Takoma Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH Several years | |
| Stokes-Adams Disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 1, 1958 to Feb. 12, 1960, that I last saw the deceased alive on Feb. 11, 1960, and that death occurred at 3:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Clinton Jackson</i> PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) M.D. RDI, Gaithersburg, Md. 2-12-60 DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 2/16/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Ash Memorial. | |
| 22d. LOCATION (City, town, or county) Sandy Spring, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Rufus L. Surden</i> | | 24a. REC'D BY REGISTRAR ADDRESS Rockville, Md. DATE FEB 15 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2216

CERTIFICATE OF DEATH

Reg. Dist. No.

02156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's RFD | | c. LENGTH OF STAY IN TB 10 yr. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | X d. STREET ADDRESS RFD #1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle THOMAS | Last GRIFFIN |
| 4. DATE OF DEATH | Month FEBRUARY | Day 25 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/25/79 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Iva Griffin | 14. MOTHER'S MAIDEN NAME Anne Byram | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO Unknown | INFORMANT Morgan Lee Griffin Rt. #3 Gaithersburg, | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446X DUE TO LOBAR PNEUMONIA [INTERVAL BETWEEN ONSET AND DEATH] 3 DAYS | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO URFMII 2 MONTHS (c) ARTERIOSCLEROTIC KIDNEY DISEASE 1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DECUBITUS ULCERS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 23 Jan 1954 to 28 Feb 1964 that I last saw the deceased alive on 25 Feb 1960, and that death occurred at 8:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John Fawcett M.D. DAWSONVILLE DATE SIGNED PHYSICIAN'S NAME (Type) JOHN. FAUCETT P.O. BOYD MARYLAND 2/28/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-2-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Walker Chapel | 22d. LOCATION (City, town or county) (State) Madison, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber Laytonsville, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE MAR 1 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&20 Film 250 1-19-60 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

02157

2139

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

unknown

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

8014 Barron Street NW.

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED
(Type or print)

First William

Middle Clarence

Last Griffin

4. DATE OF DEATH

Month Feb.

Day 4

Year 1960

5. SEX Male

6. COLOR OR RACE White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH
WIDOWED DIVORCED

4/19/1885

9. AGE (in years
from birthday)
74 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

10b. KIND OF BUSINESS OR INDUSTRY U.S. Senate Bldg.

11. BIRTHPLACE (State or foreign country) Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME George M. Griffin

14. MOTHER'S MAIDEN NAME Catherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO none

INFORMANT

Mary J. Griffin 8014 Barron St. Md.

Address Takoma Pk.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4/19/60

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Had a fall & exposure to cold (Part II)

INTERVAL BETWEEN
ONSET AND DEATH
9 days

Chronic Cardiac renal disease - years years

Valvular heart disease since age 11 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o). 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter no/one of injury in Part I or Part II of item 18)

Fell off back porch

20c. TIME OF INJURY Month, Doy, Year
Hour a. m. p. m. 1 26 1960

20d. INJURY OCCURRED

White Not white

at work at work

20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Home

21. I certify that I attended the deceased from

1960 to Feb 4, 1960, that I last saw the deceased alive on

Feb 3, 1960, and that death occurred at 12 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
TIMEKEEPER

PHYSICIAN'S
NAME (Type)

BURIAL

CREMAT. ON.
REMOVAL (Specify)

Burial

DATE THEREOF

2/6/60

22c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Cemetery

22d. LOCATION (City, town, or county)

Prince Georges Co. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

The Laffines

ADDRESS

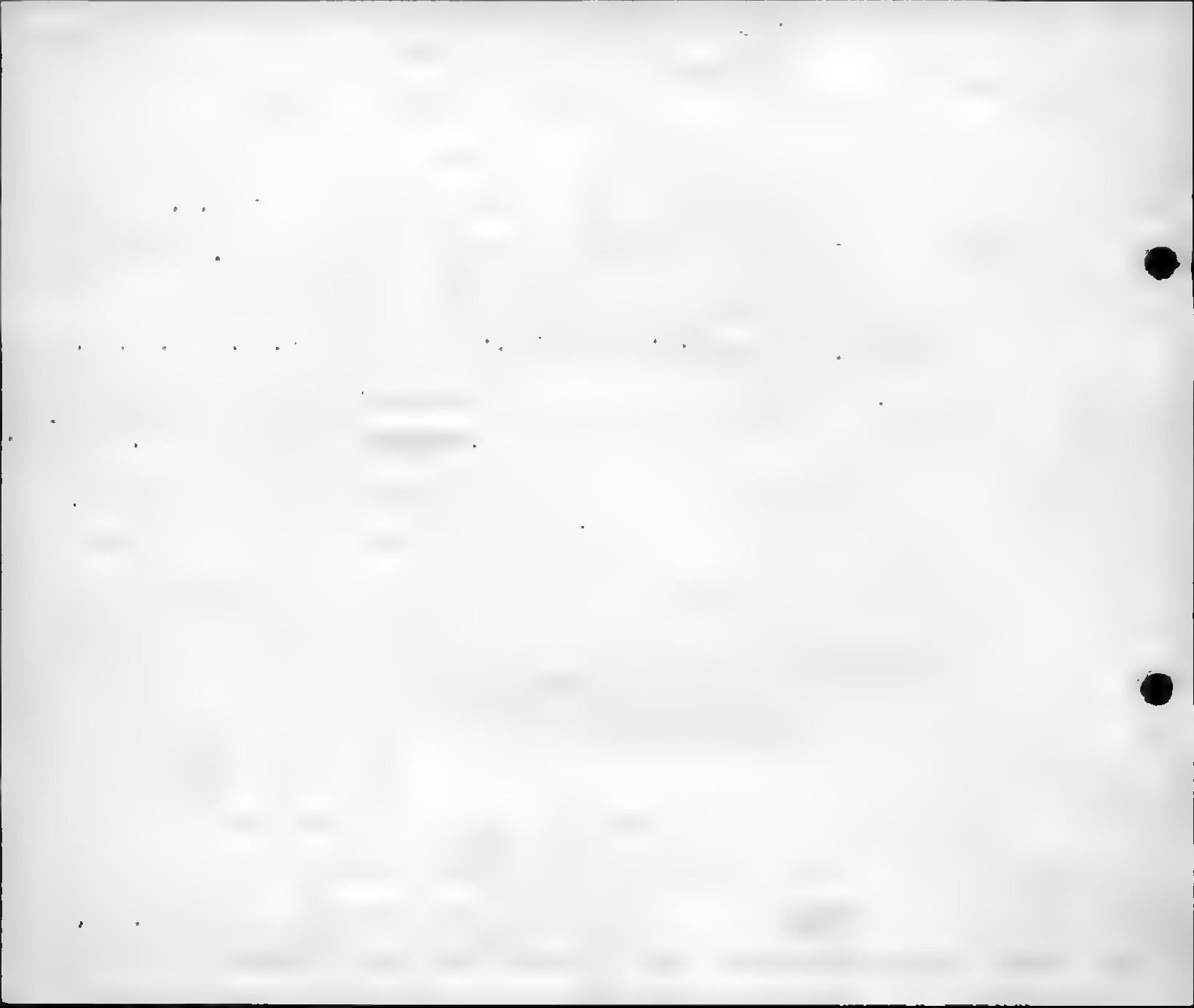
Co 2901-144710

24a. REC'D BY REGISTRAR

DATE FEB 8 '60

24b. REGISTRAR'S SIGNATURE

A. L. Lewis & Trans



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2217 CERTIFICATE OF DEATH

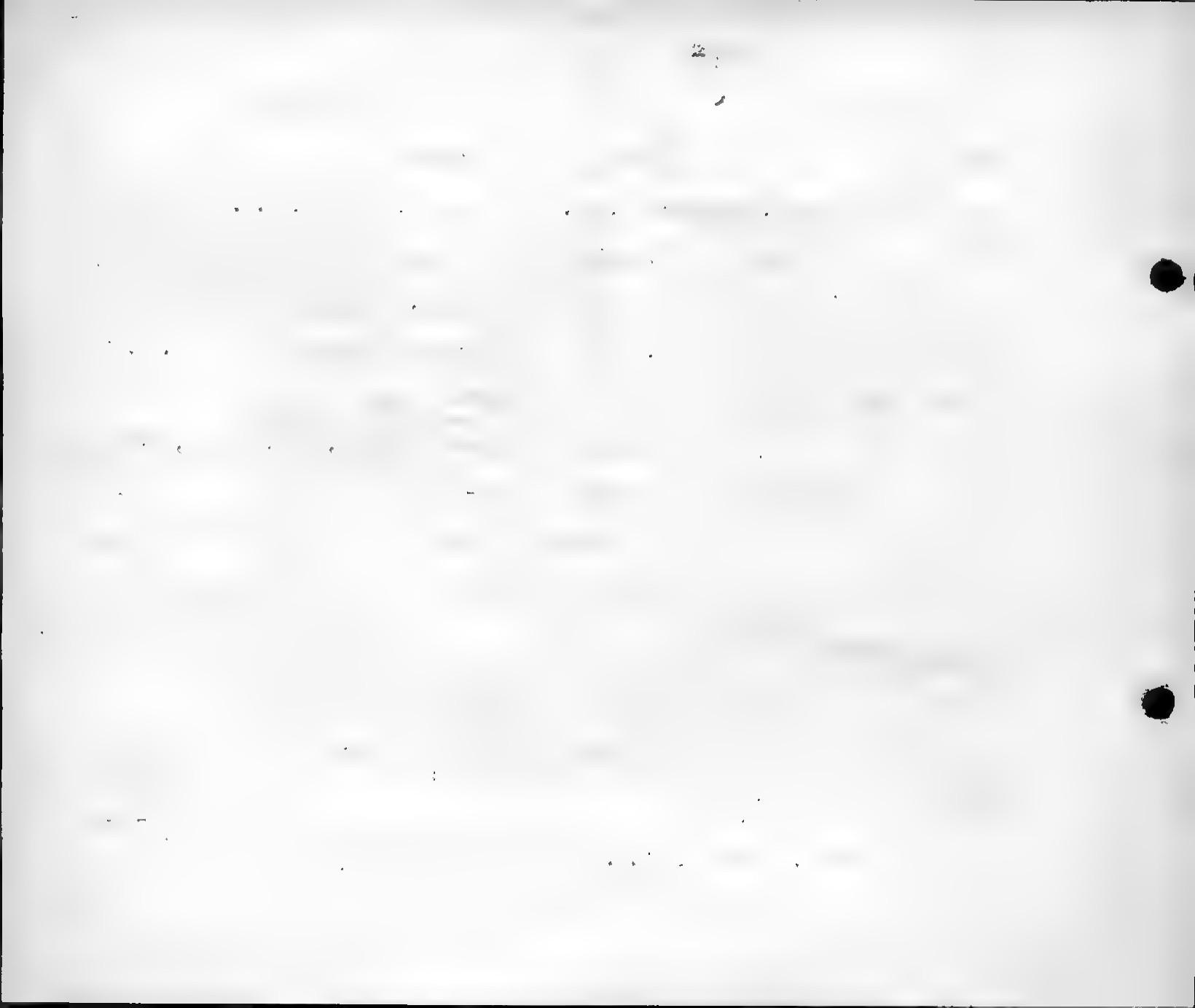
Reg. Dist. No.

02158

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|--|----------------------------------|---|--|---|--|--|-------|-----------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 28 days | | 2. USUAL RESIDENCE (Where deceased lived if institution res done before admission) o STATE District of Columbia | | | | |
| | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | |
| | | | | | | d. STREET ADDRESS 1436 Whittier Place, N.W. | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Toby | | First | Middle | Last | 4. DATE OF DEATH February 24 | Month | Day | Year , 1960 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH November 10, 1940 | 9. AGE (in years last birthday) 19 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours | Min | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Student) | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 13. FATHER'S NAME Nathan Gutwerk | | 14. MOTHER'S MAIDEN NAME Sabina Naiman | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hemorrhage into the Mid-Brain | | INTERVAL BETWEEN ONSET AND DEATH Hours | | | | | | | | |
| DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost d04.3 | | | | | | | | | | |
| (b) Acute Myelogenous Leukemia | | Months | | | | | | | | |
| DUE TO (c) | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I attended the deceased from January 27, 1960 , to February 24, 1960 that I last saw the deceased alive on February 24, 1960 , and that death occurred at 6:40 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 2-24-60 | | | | | | | | |
| ACTUAL SIGNATURE RICHARD C. MECHANIC | | DATE SIGNED 2-24-60 | | | | | | | | |
| PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D. | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-25-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEM. GARDEN FALLS CHURCH | | 22d. LOCATION (City, town, or county) VA | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B DANZANSKY & SONS - 3501 - 14th ST. N.W. | | ADDRESS | | 24a. REG'D BY REGISTRAR FEB 26 1960 | | 24b. REGISTRAR'S SIGNATURE John J. Danzansky | | | | |
| | | | | DATE | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2140

CERTIFICATE OF DEATH

Reg. Dist. No.

02159

| | | | | | | | | | |
|--|--|---|--------|---|---|--|-----|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside Corporate limits, write RURAL and give nearest town) <i>Towson Park</i> | | c. LENGTH OF STAY IN 1b <i>17</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i> | | d. STREET ADDRESS <i>Crane's Trailer Court</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hosp.</i> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Stewart</i> | | First | Middle | Last | 4. DATE OF DEATH <i>Feb 10, 1960</i> | Month | Day | Year | |
| 5. SEX <i>M.</i> | | 6. COLOR OR RACE <i>Wh.</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>Oct 28, 1904</i> | 9. AGE (in years last birthday) <i>55 yrs.</i> | 11. IF UNDER 1 YR. OR IF UNDER 24 HRS Months Days Hours Min | | | |
| 8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Holiday Inn</i> | | 11. BIRTHPLACE (State or foreign country) <i>New York</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Arthur Holiday</i> | | 14. MOTHER'S MAIDEN NAME <i>Klein</i> | | | | | | | |
| 15. WAS EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Hospital Records</i> | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> | | | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause lost (b) | | DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> | | (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1019 University Boulevard</i> | | 20f. (City or town) <i>Baltimore</i> | | (County) (State) | |
| 21. I certify that I attended the deceased from <i>January 26, 1960</i> to <i>Feb 12, 1960</i> , that I last saw the deceased alive on <i>Feb 12, 1960</i> , and that death occurred at <i>1019 University Boulevard</i> on the causes and on the date stated above. | | | | | | | | ADDRESS (Street, city or town, state) <i>Silver Spring Maryland</i> | |
| ACTUAL SIGNATURE <i>Boris Babkin</i> | | M.D. <i>Feb 17, 1960</i> | | | | | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <i>Boris Babkin</i> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Feb 17, 1960</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Hill Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Baltimore City</i> | | (State) <i>Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walker</i> | | ADDRESS <i>254 Carroll St. NW</i> | | 24a. REC'D BY REGISTRAR <i>Feb 17 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2218 CERTIFICATE OF DEATH

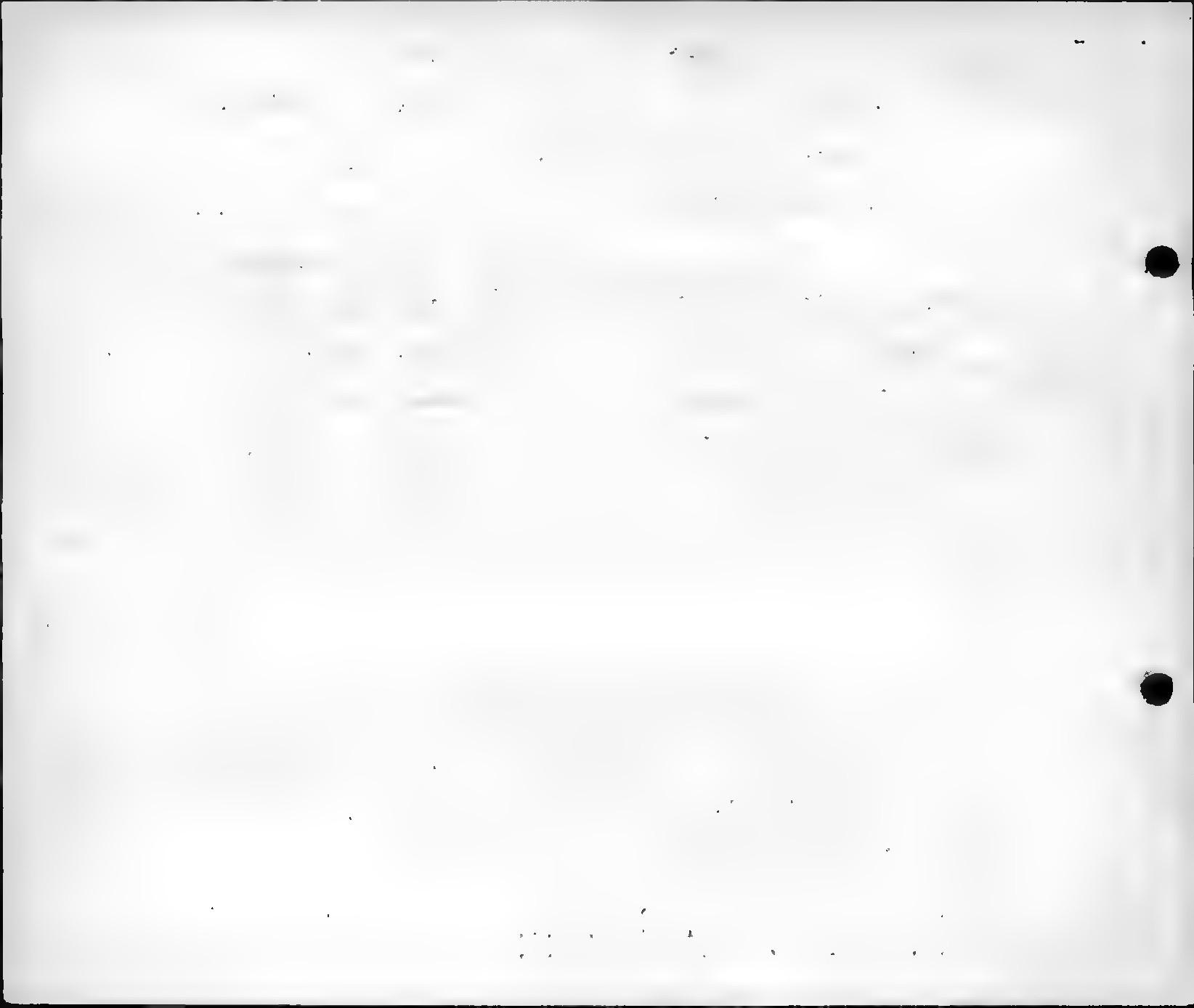
Reg. Dist. No.

02169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. STREET ADDRESS 3804 Veazey Street N.W. | |
| 3. NAME OF DECEASED (Type or print) Grace L. Harding | | First Grace | Middle L |
| 4. DATE OF DEATH February 1 1960 | Last Harding | Month February | Day 1 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 9, 1874 |
| 9. AGE (In years last birthday) 85 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 13. FATHER'S NAME Wallace | 14. MOTHER'S MAIDEN NAME Adelaide Kelly | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No | |
| 16. SOCIAL SECURITY NO none | INFORMANT Son | 17. ADDRESS Same as above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Failure | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 443x | | | |
| (b) Hypertensive Cardio vascular disease | | 17 yrs + | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 30, 1960 , to Feb. 1, 1960 , that I last saw the deceased alive on Jan. 30, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Karl Dotzbach | | ADDRESS (Street, city or town, state) M.D. Washington Clinic | |
| PHYSICIAN'S NAME (Type) Karl Dotzbach, M.D. | | DATE SIGNED 2/1/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 2/3/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery | | 22d. LOCATION (City, town or county) (State) Leesburg, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C. | | 24a. REC'D BY REGISTRAR FEB 2 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE John S. Hines | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2219 CERTIFICATE OF DEATH

Reg. Dist. No.

02161

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admis'sn) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown-Rural | | c. LENGTH OF STAY IN 1b 2 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle William | Last Harman |
| 4. DATE OF DEATH | Month February | Day 16 | Year 19 60 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 29, 1877 |
| 9. AGE (In years (on birthday) 82) yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Hours | 12. IF UNDER 24 HRS Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John E. Harman | | 14. MOTHER'S MAIDEN NAME Elizabeth Best | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Lester Harman-son-City 13, Rockville Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last { DUE TO (b) DUE TO (c) DUE TO | | | |
| <i>Acute congestive heart failure</i> , Arteriosclerotic heart disease , Generalized arteriosclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1959 to 16 Feb 1960 that I last saw the deceased alive on 16 Feb 1960 , and that death occurred at 12:05 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W.G. Hall</i> | | ADDRESS (Street, city or town, state) 615 W. Montg. Ave. Rockville, Md. | |
| PHYSICIAN'S NAME (Type) W. G. Hall | | DATE SIGNED 2/19/60 | |
| 22a. BURIAL, CREMATION, REMOVAL. (Specify) Burial | | 22b. DATE THEREOF 2/19/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery | | 22d. LOCATION (City, town, or county) Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR FEB 23 '60 | | 24b. REGISTRAR'S SIGNATURE Cathleen S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

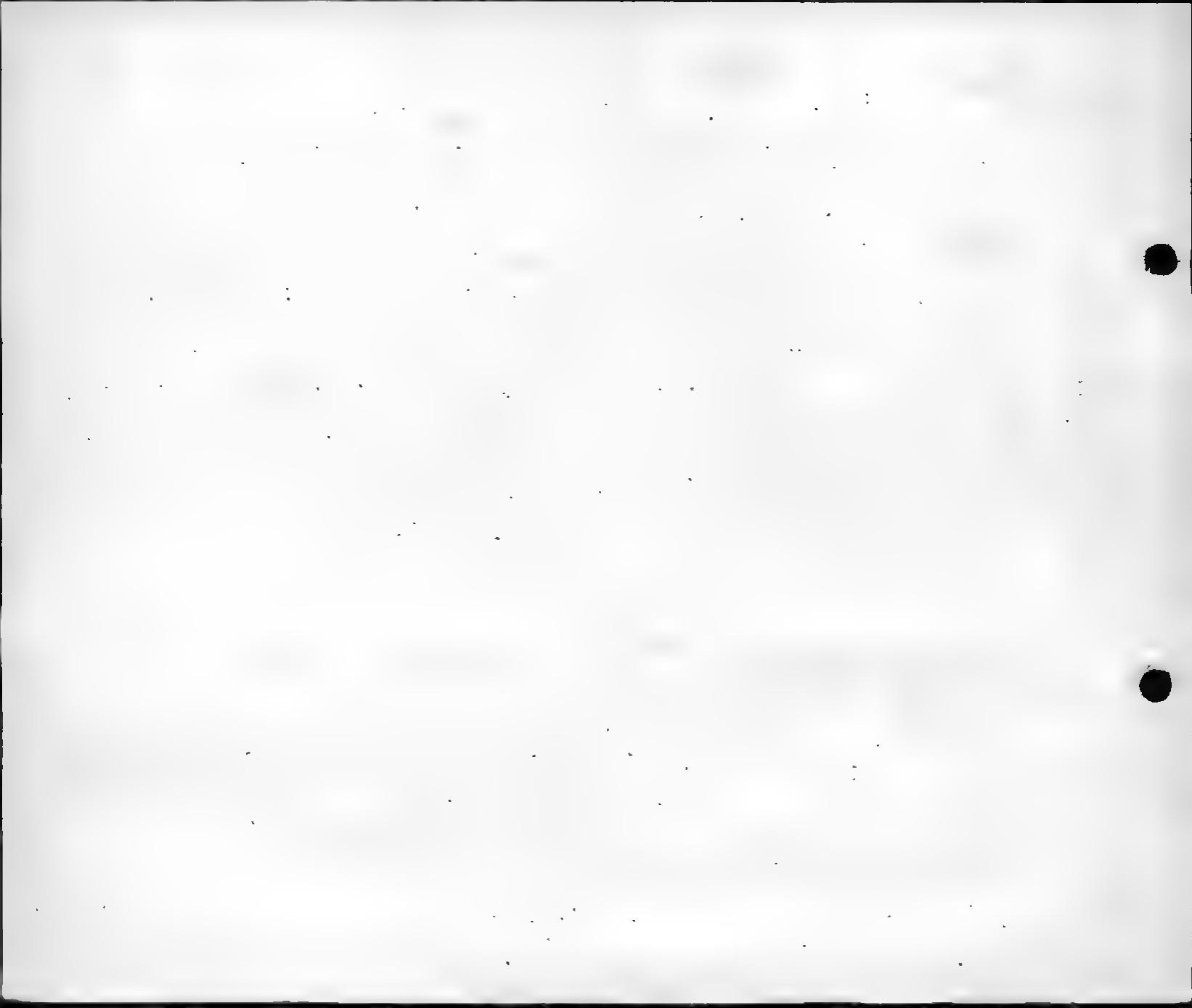
Reg. Dist. No.

02162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | |
| MONTGOMERY MARYLAND | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Silver SPRINGS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver SPRINGS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8922-Georgia Ave. | | d. STREET ADDRESS 8922 Georgia Ave Silver Spring | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| ELIZABETH LAWRENCE HARRINGTON | | | |
| Last | | 4. DATE OF DEATH | Month |
| | | FEB | Day |
| | | 18 | Year |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| FEMALE WH | | | B. DATE OF BIRTH No 25, 1877 |
| 8. AGE (In years last birthday) | | 9. IF UNDER 1 YEAR | 10. IF UNDER 24 HRS. |
| 82 yrs | | Months 3 | Days 18 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Va |
| | | | 12. CITIZEN OF WHAT COUNTRY? MONTGOMERY |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME MARY ELIZABETH FORD | |
| J.W. CHICHESTER | | INFORMANT John F. HARRINGTON - 8922 Georgia Ave Silver Spring | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | Address SILVER SPRINGS | |
| No | | | |
| 16. SOCIAL SECURITY NO. | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| (If yes, give war or dates of service) | | 1 month | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | 7. | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO Cardiofailure | |
| 155.1 | | (b) DUE TO Carcinomatosis | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (c) DUE TO Primary O. gas troader | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, office, (City or town), factory, street, office bldg., etc.) | | (County) (State) | |
| 21. I certify that I attended the deceased from alive on <u>Feb 18, 1960</u> , and that death occurred at <u>8:10 p.m.</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>John F. Harrington, M.D.</u> | | ADDRESS (Street, city or town, state) 3810-12 NE DATE SIGNED | |
| PHYSICIAN'S NAME (Type) | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| | | 22b. DATE THEREOF 2/22/60 | |
| | | 22c. NAME OF CEMETERY OR CREMATORIUM PRESBYTERIAN CH. ALEXANDER | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hardin - 3831 - Ga. Ave.</u> | | 22d. LOCATION (City, town, or county) (State) Va | |
| | | 24a. REC'D BY REGISTRAR DATE FEB 24 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hank</u> | |

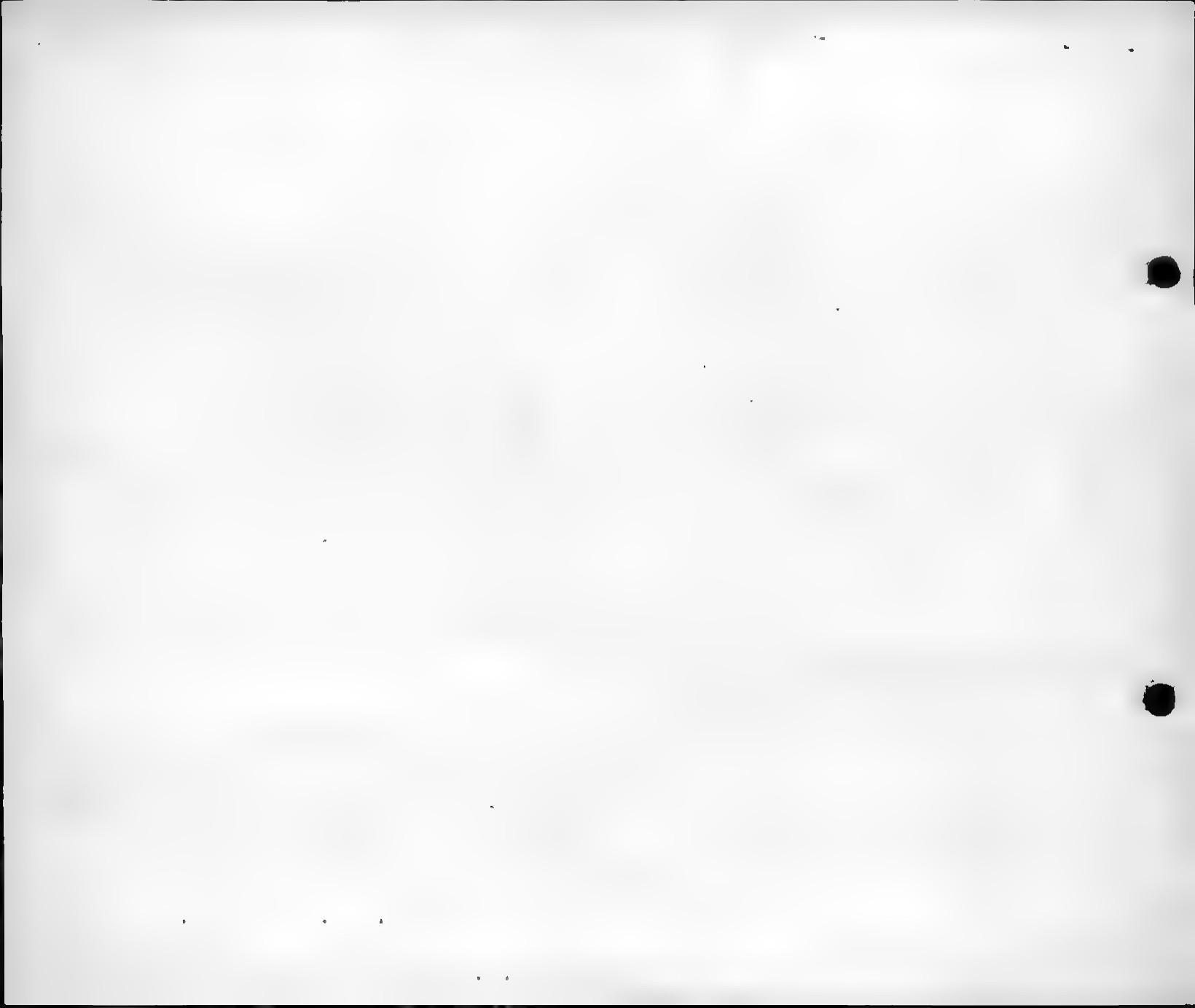


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2141 CERTIFICATE OF DEATH

02163

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | c. LENGTH OF STAY IN 1b <i>40 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private residence</i> | e. STREET ADDRESS <i>2201-1447 NW Washington, D.C.</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Annie Margaret Harris</i> | First <i>Annie</i> | Middle <i>Margaret</i> | Last <i>Harris</i> |
| 4. DATE OF DEATH <i>Feb. 1, 1960</i> | Month <i>Feb.</i> | Day <i>1</i> | Year <i>1960</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-27-74</i> |
| 9. AGE (In years last birthday) <i>80 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS. Hours <i>0</i> | 12. IF UNDER 24 HRS. Minutes <i>0</i> |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | 12 CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <i>A. F. +</i> | 14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Mason</i> | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO | INFORMANT <i>R. A. Hare</i> | 17. INTERVAL BETWEEN ONSET AND DEATH <i>one week</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> | | | |
| DUE TO <i>434.1</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (If either, notify medical examiner) | | | |
| DUE TO <i>Congestive Heart Failure</i> | | | |
| (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month <i>Feb.</i> | Day <i>1</i> | Year <i>1960</i> |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Takoma Park, Md.</i> | (County) <i>Takoma Park, Md.</i> |
| (State) <i>Md.</i> | | | |
| 21. I certify that I attended the deceased from <i>Feb. 1, 1960</i> , to <i>Feb. 1, 1960</i> , that I last saw the deceased alive on <i>Feb. 1, 1960</i> , and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i> | | | DATE SIGNED <i>2/4/60</i> |
| MEDICAL CERTIFICATION | | | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>2/4/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cem. Ft. Myer, Va.</i> |
| 22d. LOCATION (City, town, or county) <i>Ft. Myer, Va.</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare</i> | | ADDRESS <i>2901-1447 NW Washington, D.C.</i> | 24a. REC'D BY REGISTRAR <i>Arthur E. Kraus</i> |
| | | DATE FEB 2 '60 | 24b. REGISTRAR'S SIGNATURE |
| VS A15 (4) 15M 9/5B | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02164

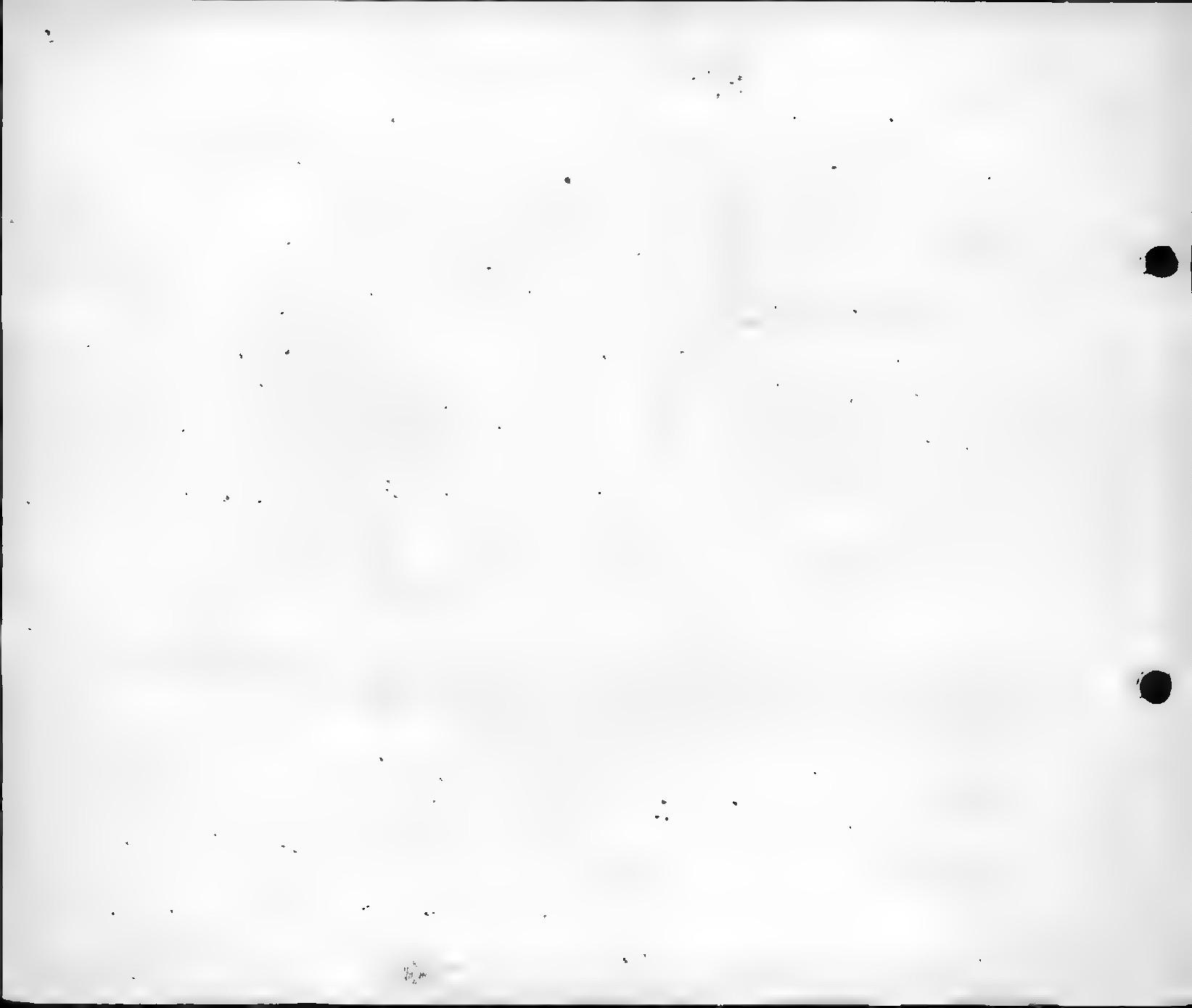
CERTIFICATE OF DEATH

Reg. Dist. No.

2220

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14571 Colleville Rd. | | c. LENGTH OF STAY IN 1b 1 yr 24 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARIE EA SANATORIUM | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Airton | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) SADYE N. MADDox | First S | Middle A | Last HAYDEN |
| 4. DATE OF DEATH Feb 15 1960 | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 2-1886 |
| 9. AGE (In years last birthday) 73 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. HOURS 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (State or foreign country) CHARLES CO. MD | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME JOHN W. MADDox | 14. MOTHER'S MAIDEN NAME ELLA SMITH | Address 1808 Parkwood Dr Md | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO unknown | INFORMANT L. Edwin Hayden | INTERVAL BETWEEN ONSET AND DEATH Edney |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) baseball bounces accident (b) Generalized arteriosclerosis (c) age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis (c) age | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | |
| 21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Hall Geer, M.D. | | ADDRESS (Street, city or town, state) 1818 Lamansay St Bel Airton, Md. | DATE SIGNED 2-15-60 |
| PHYSICIAN'S NAME (Type) J. Hall Geer | | | |
| 22a. BUR. AL. CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-18-60 | 22c. NAME OF CEMETERY OR CREMATORIAL St Ignatius Lm. Bel Airton, Md. | 22d. LOCATION (City, town, or county) (State) Bel Airton, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661 Parkwood Hopkins Street Bel Airton, Md. | ADDRESS 1661 Parkwood Hopkins Street Bel Airton, Md. | 24a. REC'D BY REGISTRAR FEB 17 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02165

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PHQ3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File copies 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2179

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) | |
| Montgomery Rockville | | b. STATE Maryland c. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. LENGTH OF STAY IN lb | |
| Rockville | | life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. DATE OF DEATH | |
| 304 N. Adams St. Apt. 160 | | Feb 21 1960 | |
| 3. NAME OF DECEASED (Type or print) | | f. 15 RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Sherry Ann Henderson | | g. AGE [In years (at birthday)] 2 yrs. | |
| 4. SEX female white | | h. IF UNDER 1 YEAR Months Days Hours Min | |
| 5. COLOR OR RACE | | i. IF UNDER 24 HRS Hours Min | |
| 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | j. 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | k. 13. FATHER'S NAME Howard Henderson | |
| l. 14. MOTHER'S MAIDEN NAME Mattie Ruth Rainey | | m. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Val. no. or unknown) <input type="checkbox"/> n. 16. SOCIAL SECURITY NO | |
| n. 17. INFORMANT Howard Henderson (father) J.D. 2 | | o. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Epileptic Seizure Conditions, if any, which gave rise to immediate cause (b) DUE TO Cerebral G淤血 (c) DUE TO | |
| p. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | q. 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| r. 20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | s. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| t. 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | u. 20f. (City or town) (County) (State) | |
| v. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| w. ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | x. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| y. 22a. BURIAL, CREMATION OR REMOVAL (Specify) Bur-Transit | | z. 22b. DATE THEREOF 2/22/60 | |
| AA. 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Evergreen | | BB. LOCATION (City, town, or county) Macon, Georgia (State) | |
| CC. 23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montg. Ave. Funeral Home Rockville, Md. | | DD. REC'D. BY REGISTRAR FEB 24 1960 | |
| EE. 24b. REGISTRAR'S SIGNATURE Albert S. Nease | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12166

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FEDNOR</i> | | b. COUNTY <i>Prince Georges</i> | |
| c. LENGTH OF STAY IN 1b <i>1 MON. 3 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>Belmont Farm Nursing Home</i> | | d. STREET ADDRESS <i>4118-29th Street</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Otto. Theodore Herzberger</i> | | 4. DATE OF DEATH Month <i>2</i> Day <i>13</i> Year <i>1960</i> | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>12-23-1860</i> | | 9. AGE (In years last birthday) yrs <i>99</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth G. Laughton</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO <i>None</i> | |
| 17. INFORMANT <i>Eliz. G. Laughton</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO <i>Anemia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Parkinsonism</i> DUE TO <i>Chronic pyelonephritis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 wk.</i> Yrs | |
| 19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from olive an <i>2/7/60</i> , and that death occurred at <i>5:07 A.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Sandy Spring, Md.</i> | |
| ACTUAL SIGNATURE <i>C. H. Hanson</i> | | DATE SIGNED <i>2/13/60</i> | |
| PHYSICIAN'S NAME (Type) <i>C. H. Hanson</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>2/16/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i> | | 22d. LOCATION (City, town, or county) <i>Belmar Manor, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Inc.</i> | | 24a. REC'D BY REGISTRAR ADDRESS <i>Mt. Rainier, Md.</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | |



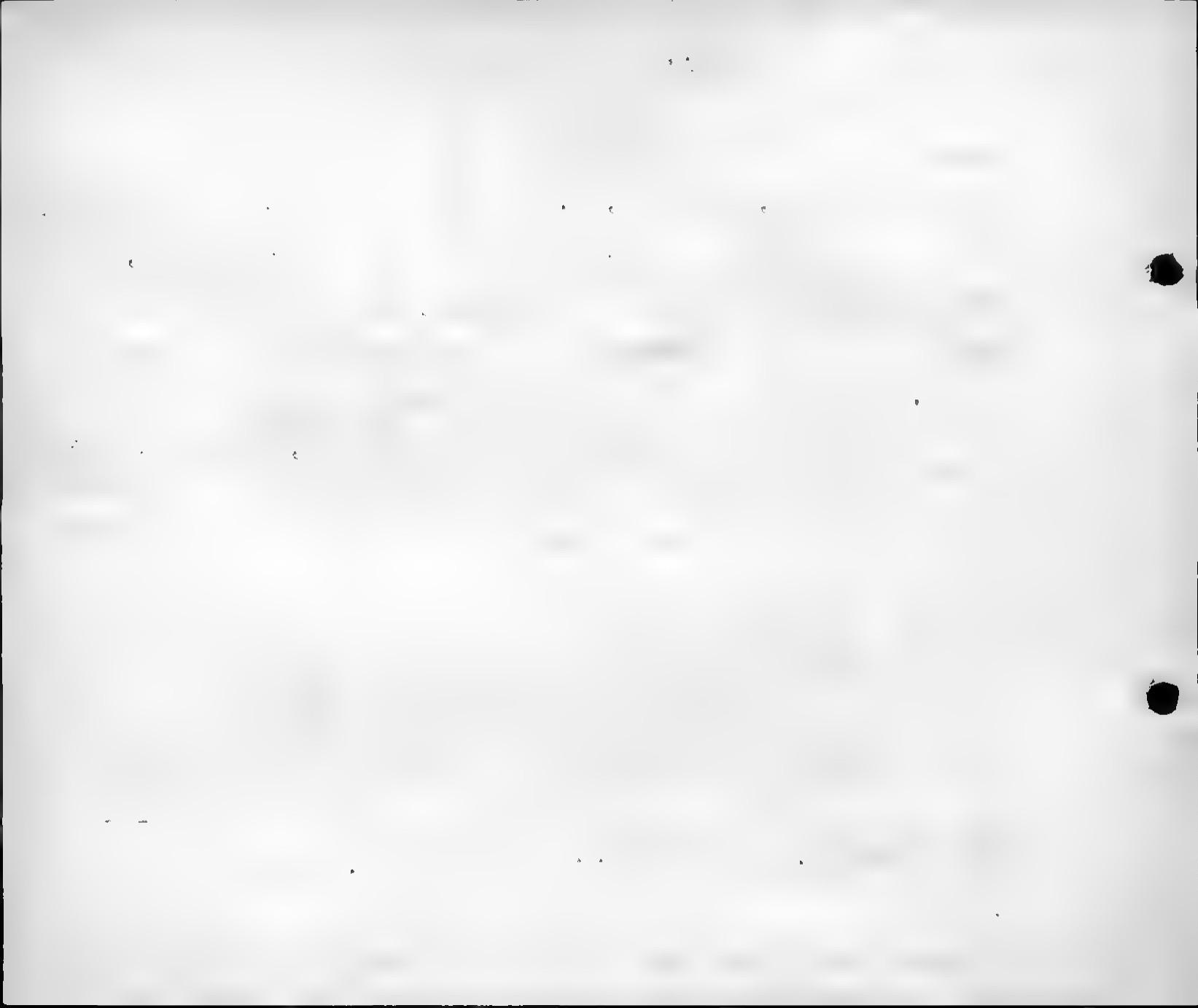
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2222 CERTIFICATE OF DEATH

02167

Reg. Dist. No.

| | | | | | | | | |
|--|----------------------------------|---|--|--|---------------------------------------|---|--|-----------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE West Virginia | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 49 days | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beckley | | | | |
| 3. NAME OF DECEASED (Type or print) Martha | | | | First Eleanor | Middle Hickman | Last February 26, 1960 | 4. DATE OF DEATH Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 1, 1910 | 9. AGE (In years last birthday) 49 yrs. | F UNDER 1 YEAR Months 12 | IF UNDER 24 HRS Days 0 | Hours 0 | Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | | | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Stan H. Downey | | | | 14. MOTHER'S MAIDEN NAME Ada Lawson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of the Cervix DUE TO (c) 2 Years INTERVAL BETWEEN ONSET AND DEATH 2 Weeks | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from January 8, 1960 , to February 26, 1960 that I last saw the deceased alive on February 26, 1960 , and that death occurred at 6:05 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Beckley DATE SIGNED 2-26-60 | | | | | | | | |
| ACTUAL SIGNATURE Edward D. McLaughlin, M.D. PHYSICIAN'S NAME (Type) EDWARD D. McLAUGHLIN, M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 2-27-60 | | 22b. DATE THEREOF 2-27-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 389 Pelham Street, Bethesda 14, Md. | | 22d. LOCATION (City, town, or county) Beckley (State) W. Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Trojani Funeral Home Inc., Bethesda 14, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 3 '60 | | 24b. REGISTRAR'S SIGNATURE John S. Khan | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

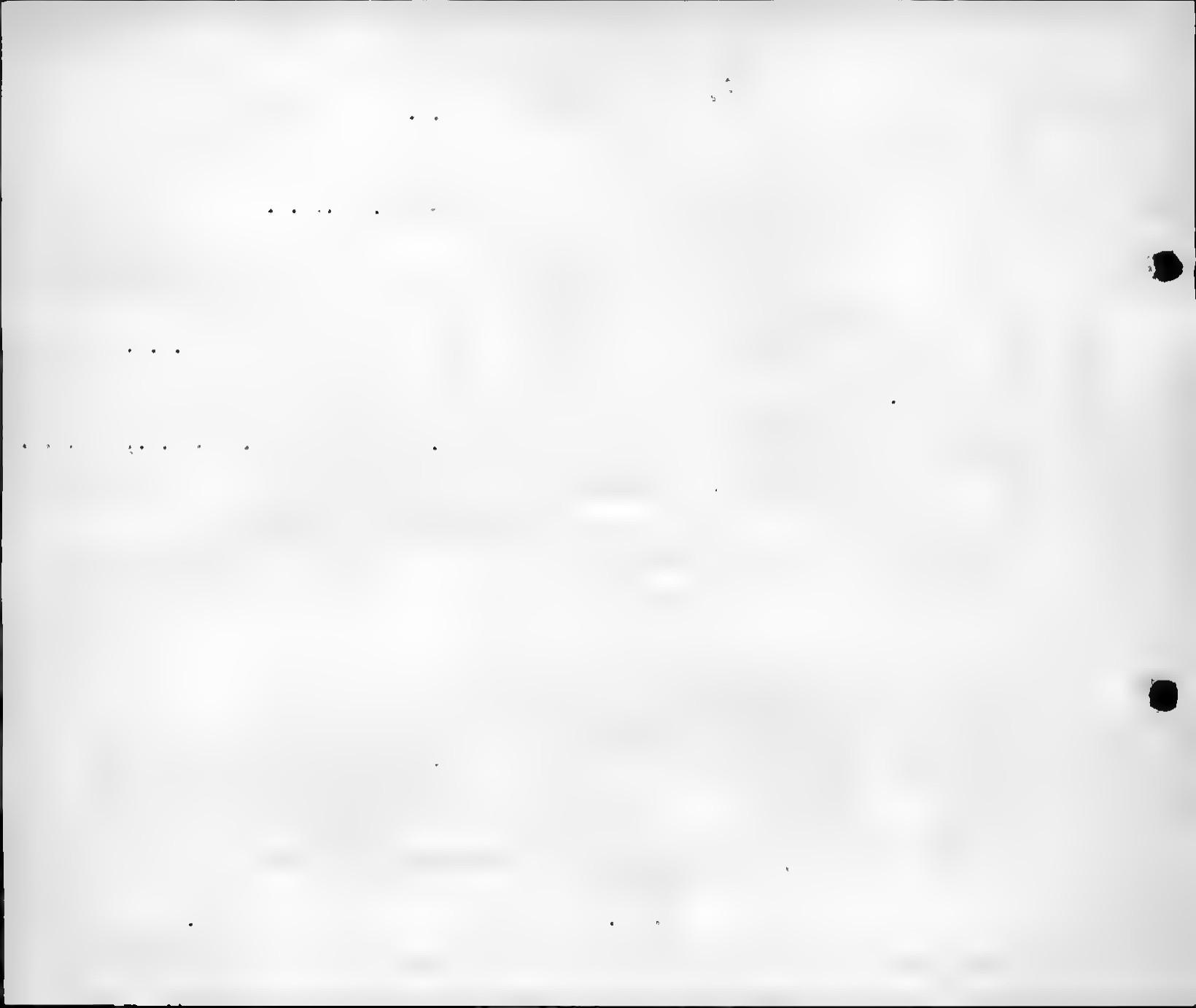
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2170 CERTIFICATE OF DEATH

Reg. Dist. No.

02168

| | | | | | |
|--|--|---|----------------|---|--|
| PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b #3 weeks | | d. STATE D.C. | |
| KENSINGTON | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Kensington Gardens Sanitarium | | d. STREET ADDRESS 1217-39th St., N.W., Washington, D.C. | |
| 3. NAME OF DECEASED (Type or print) | | First William John | Middle Hill | Last Hill | 4. DATE OF DEATH February 2 Month Year 1960 Day 19 Year 19 |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar 4, 1879 |
| 9. AGE (In years at death) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lived in Irvinia, Dressman in Irvinia | | 11. BIRTHPLACE (State or foreign country) Engl. & F | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William W. Hill | | 14. MOTHER'S MAIDEN NAME Mary Anne Drew | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | INFORMANT Mrs. Ethel J. Hill, 1217-39th St., N.W., Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 340.3 | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Infection, location undetermined, possible meningitis (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from alive on February 2, 1960 | | Jan 26, 1960 | | February 2, 1960, that I last saw the deceased 6:30 p.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Feb 2, 1960 | |
| ACTUAL SIGNATURE <i>R. T. Thibadeau</i> | | PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. | | Kensington, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/5/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Watson Park Cemetery | |
| 22d. LOCATION (City, town, or county) Baltimore | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home Wash. D.C.</i> | | ADDRESS 5703 Wisconsin Ave., N.W., Washington, D.C. | | 24a. REC'D BY REGISTRAR FEB 8 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Curtis S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

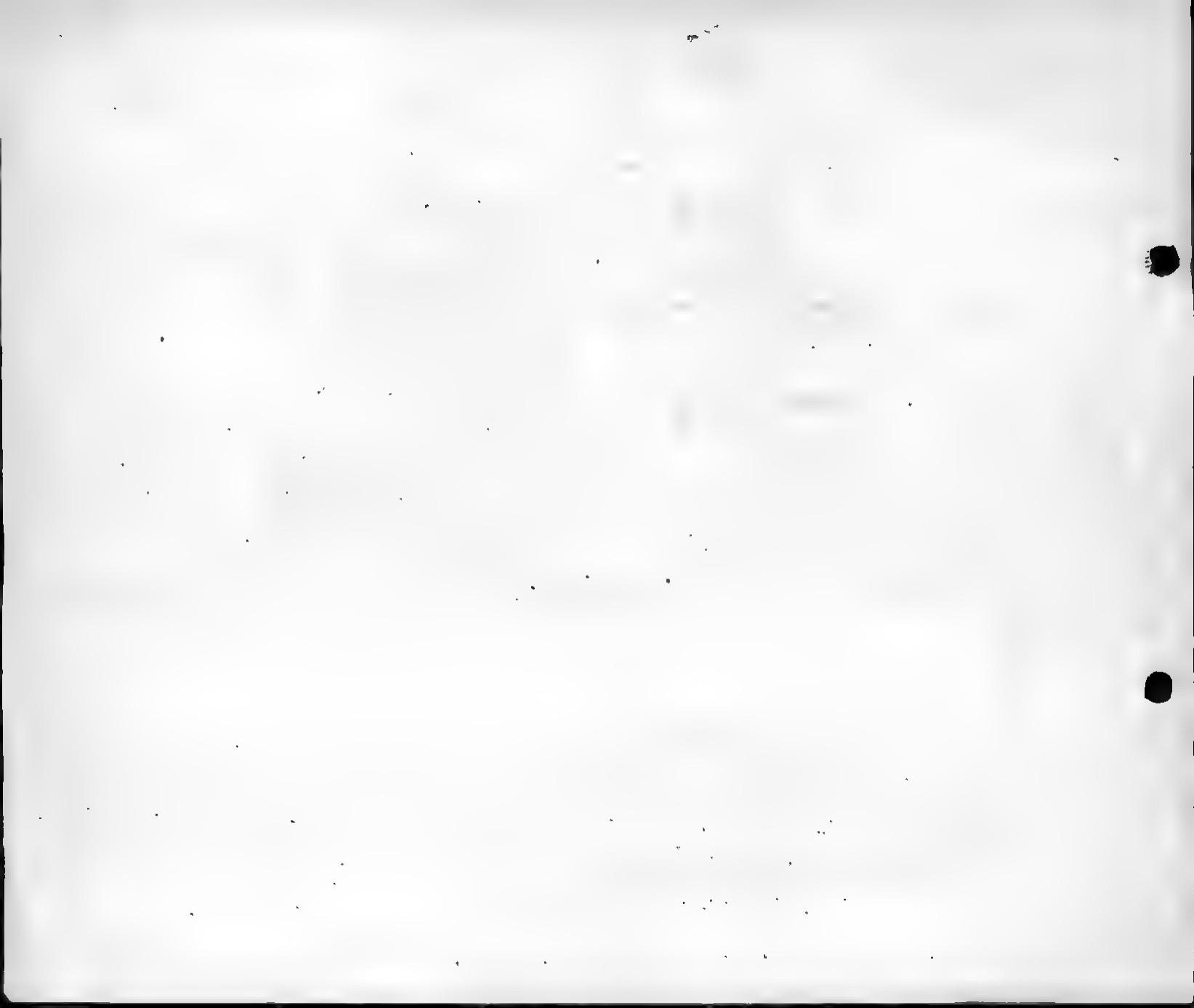
Reg. Dist. No.

02169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|---|--|---|--|---------------------------------------|---|-----------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | d. STREET ADDRESS Mapleyview Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First Fannie | Middle M. Hilton | Last | 4. DATE OF DEATH | Month February | Day 14 | Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH October 2, 1881 | 9. AGE (In years lost birthday) 89 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Days 0 | Hours 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John F. Bohrer | | | | 14. MOTHER'S MAIDEN NAME Louisa R. Duvall | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO None | INFORMANT | | Address William Griffin Maple View Drive Kensington, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X <i>Cerebral vascular accident</i> | | | | | | | | |
| DUE TO (b) <i>Hypertension with irregularities in heart</i> | | | | | | | | |
| (c) <i>Secondary cerebral vascular disease</i> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Doy 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) Elkton | (County) Carroll Co. | (State) Md. | |
| 21. I certify that I attended the deceased from Feb. 10, 1960 , to Feb. 14, 1960 , that I last saw the deceased alive on Feb. 14, 1960 , and that death occurred at 4:28 P.M. from the causes and on the date stated above | | | | | | | | |
| | | | | ADDRESS (Street, city or town, state) Kensington, Md. | | DATE SIGNED 2/14/60 | | |
| ACTUAL SIGNATURE P. F. Andrews, M.D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) P. F. Andrews | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Feb. 17, 1960 | 22c. NAME OF CEMETERY OR CREMATORIUM Damascus Cemetery | 22d. LOCATION (City, town, or county) Damascus, Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber | | | | ADDRESS Laytonsville, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 18 '60 | | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur & Frank | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2224

CERTIFICATE OF DEATH

Reg. Dist. No.

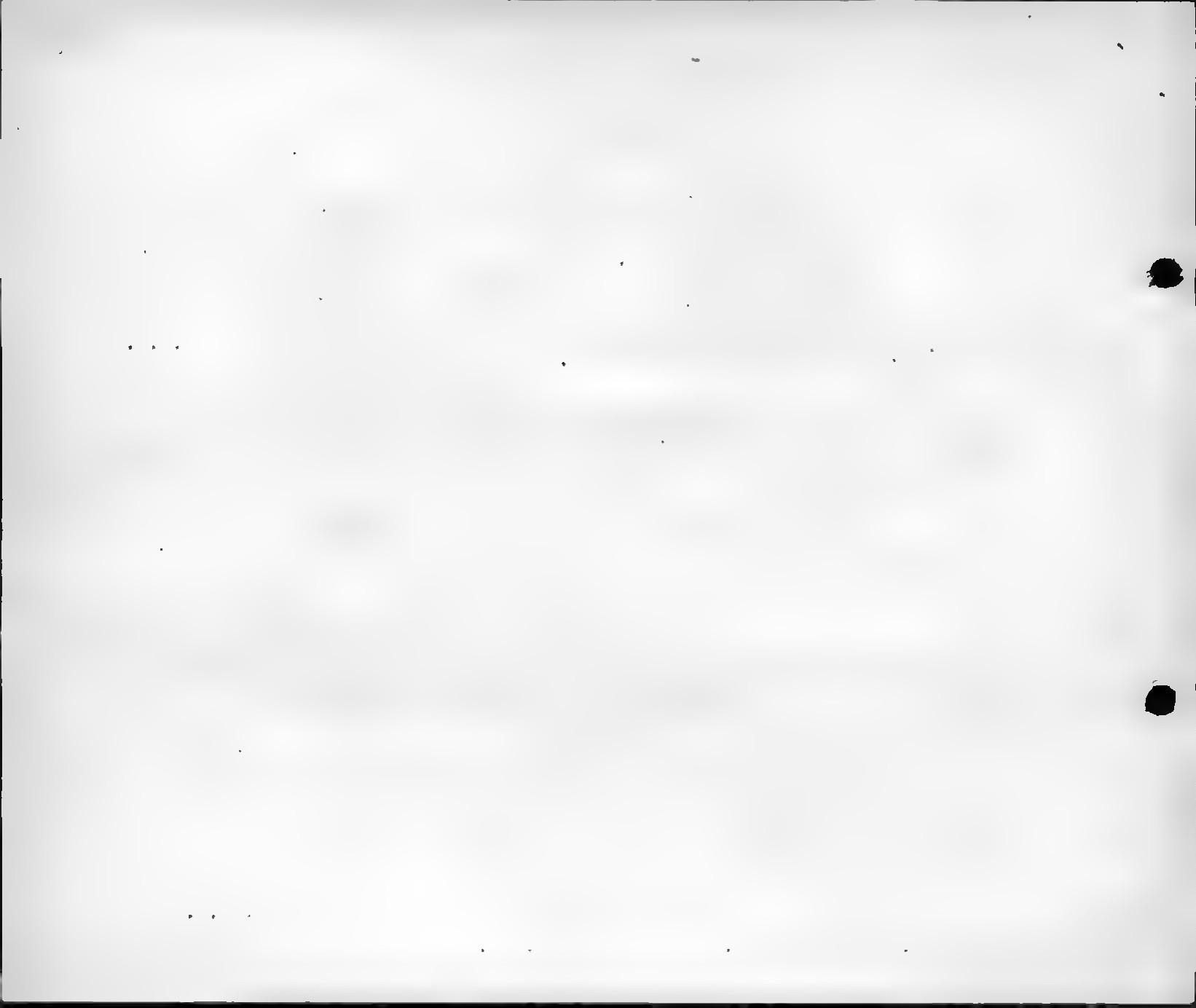
02170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

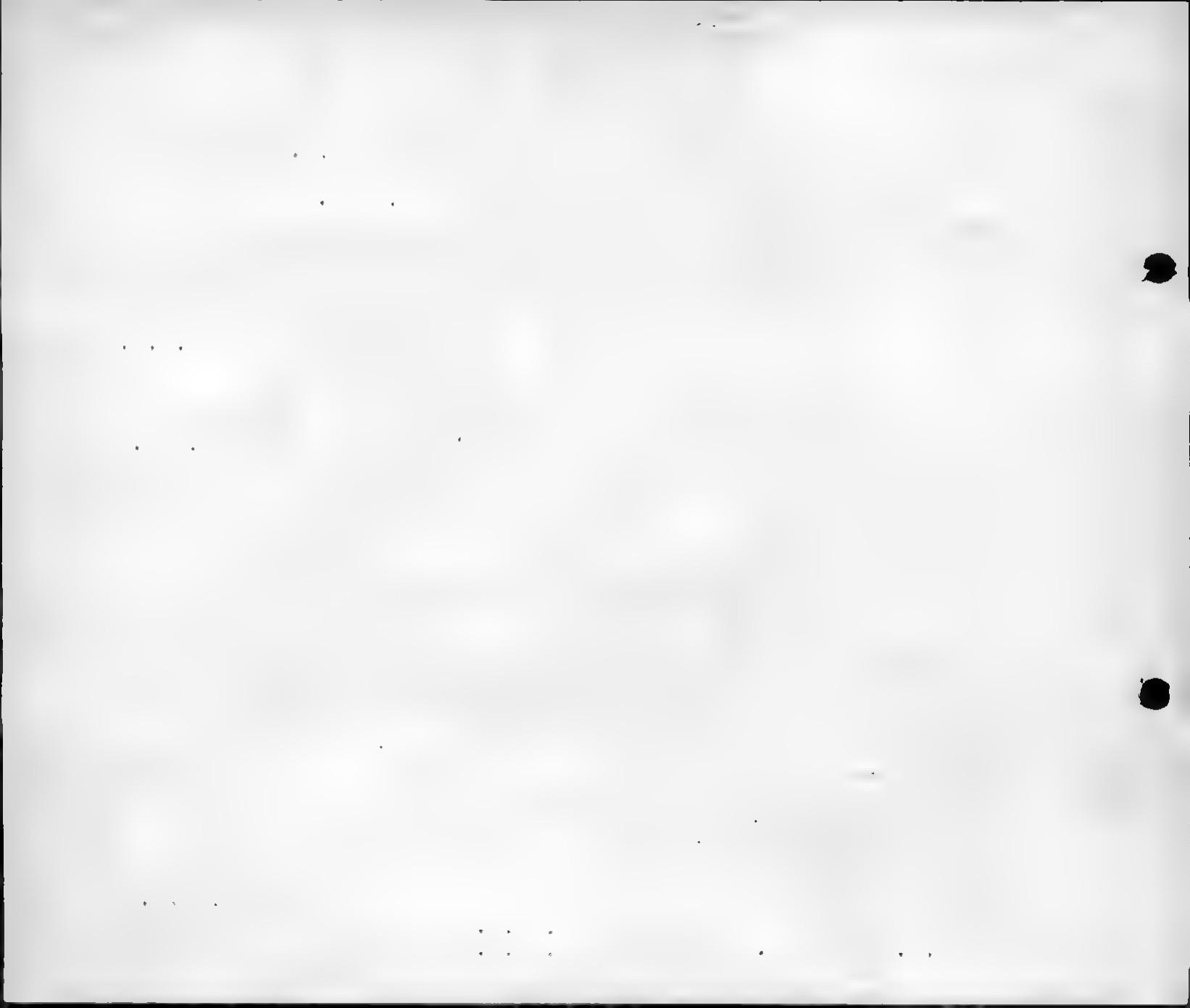
| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDMOND M.D. | | b. COUNTY MONTGOMERY | |
| c. LENGTH OF STAY IN lb 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BELMONT NURSING Home | | d. STREET ADDRESS 610 Bonifant St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Holloway | | First JOHN J. | Middle HOLLOWAY |
| Last | | DATE OF DEATH 2 | Month 8 |
| 4. DATE OF DEATH 1960 | | Day 8 | Year 1960 |
| 5. SEX M | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 3/9/68 | | 9. AGE (In years last birthday) 91 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman, (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Singer Sewing Machine Co. | 11. BIRTHPLACE (State or foreign country) VIRGINIA |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-20-175A | INFORMANT Clarie Jay Belmont Jrn. |
| 17. DUE TO PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | Address 6 mo | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Pyelonephritis | | INTERVAL BETWEEN ONSET AND DEATH 6 mo | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD |
| 20f. (City or town) Silver Spring, MD. | | (County) (State) MD | |
| 21. I certify that I attended the deceased from 10/6 , 19 59 to 2/8 , 19 60 , that I last saw the deceased alive on 2/3 , 19 60 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Silver Spring, MD. | |
| ACTUAL SIGNATURE C. H. GON | | DATE SIGNED 2/8/60 | |
| PHYSICIAN'S NAME (Type) Raymond A. Ziskin | | | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/11/60 | 22c. NAME OF CEMETERY OR CREMATORIUM GLENWOOD CEMETERY | 22d. LOCATION (City, town, or county) WASHINGTON, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPREEF, INC. | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR FEB 10 1960 |
| | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and copies sent to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | |
|--|--|------------------------|---|-----------------------------------|---------------------------------------|--|-----|--|--|----------------------------------|---|---|---|--|---|-----------------------|----------------------|
| 2171 CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | | d. STREET ADDRESS 1405 G St. N.W. | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First HATTIE | Middle MARY | Last HOOVER | 4. DATE OF DEATH FEB 7 1960 | Month | Day | Year | 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/13/71 | 9. AGE (In years last birthday) 88 | 10. IF UNDER 1 YEAR Months 88 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 | 13. Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME William Osborne | | | | | | 14. MOTHER'S MAIDEN NAME Ella Flynn | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO none | | | 17. INFORMANT James O. Hoover | | | 5705 Maiden Lane Bethesda, Md. | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral V. hemorrhage | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | |
| 332 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | | DUE TO (b) Generalized ARTERIOSCLEROSIS | | | (c) AGE | | | | | | 15 yrs | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) D.C. | | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1958 to Dec 6 1960 , that (I) (we) last saw the deceased alive on Dec 4 1960 , and that death occurred on Dec 6 1960 M. from the causes and on the date stated above | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Leo J. Donovan MD | | | | | | 22b. DATE SIGNED Feb 9 1960 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) LEO J. DONOVAN MD | | | MD ATTENDING PHYS <input type="checkbox"/> | | | MED DIRECTOR <input type="checkbox"/> | | | STAFF PHYS <input type="checkbox"/> | | | | | | | | |
| 22d. ADDRESS 5116 GEORGETOWN RD BETHESDA 14 MD | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION OR REMOVAL (Spec.) burial | | | 23b. DATE THEREOF 2/9/60 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery | | | 23d. LOCATION (City, town, or county) Washington, D.C. | | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | | | 25a. ADDRESS 2901 14th St. N.W. Washington 9, D.C. | | | 25b. REC'D BY REGISTRAR DATE FEB 9 '60 | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02172

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN lb <i>1 da</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i> | | e. STREET ADDRESS <i>5419 Buring Rd</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Margaret</i> | | First <i>H</i> | Middle <i>Horst</i> |
| 4. DATE OF DEATH Lost <i>Feb 1 1960</i> | | Month <i>Feb</i> | Day <i>1</i> |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>June 4, 1879</i> | | 9. AGE (in years last birthday) <i>80 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>11. BIRTHPLACE (State or foreign country) <i>Md.</i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| 10c. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 12. MOTHER'S MAIDEN NAME <i>Sara Linesay</i> | |
| 13. FATHER'S NAME <i>Joseph</i> | | 14. INFORMANT <i>George S. Smith-Item #2-Son-in-law</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>None</i> | |
| 17. MEDICAL CERTIFICATION | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Due to</i> <i>(b)</i> <i>Stroke of left side, ruptures left cerebral</i> <i>Due to</i> <i>(c)</i> <i>myocardial infarction (Cor. occlusion)</i> | |
| | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| | | 5 days | |
| | | 1 week | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>2/1</i> , 19 <i>60</i> , to <i>2/1</i> , 19 <i>60</i> that I last saw the deceased alive on <i>2/1</i> , 19 <i>60</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Brink B Rude</i> M.D. <i>3900 Muletiny Rd NW DC</i> <i>Gilbert B. Rude</i> | |
| ACTUAL SIGNATURE <i>Gilbert B. Rude</i> | | DATE SIGNED <i>2/1/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Robert A. Pumphrey, Bethesda, Maryland</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | |
| 22b. DATE THEREOF <i>2-5-60</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat'l Cem.</i> | |
| 22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i> | | 24a. REC'D BY REGISTRAR DATE <i>Feb 4 '60</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File #256 2-19-60 et

02173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Montgomery

2225

MARYLAND

2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission]

a. STATE

Maryland

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ashton

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Ashton

d. STREET ADDRESS

"Mount Airy"

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
FLOYDMiddle
E.Last
Huntley4. DATE
OF
DEATHMonth
2Day
13Year
1960

5. SEX

6. COLOR OR RACE

7 MARRIED NEVER MARRIED

8. DATE OF BIRTH

Oct. 10, 1881

9 AGE (In years
at birthday)
yrs.

78 9

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS

Months

Days

Hours

Min

Male

White

WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Publisher

11. BIRTHPLACE (State or foreign country)

Cherry Creek N.Y.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Reed Huntley

14. MOTHER'S MAIDEN NAME

Fidelia Frost

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

INFORMANT

Myrtle Huntley

Address

Ashton Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Adenocarcinoma of colon
with metastasesINTERVAL BETWEEN
ONSET AND DEATH

4 yrs

15-3

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.{ (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956 to 2/13/1960, that I last saw the deceased alive on 2/13/1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John H. L. Johnson

M.D.

Sandy Spring, Md.

2/13/60

PHYSICIAN'S
NAME (Type)

C. H. L. Johnson

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Shipped 2/15/60

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

Forrest Lawn Cemetery

22d. LOCATION (City, town, or county)

Buffalo,

(State)

N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE

Joseph Hawley & Son Inc.

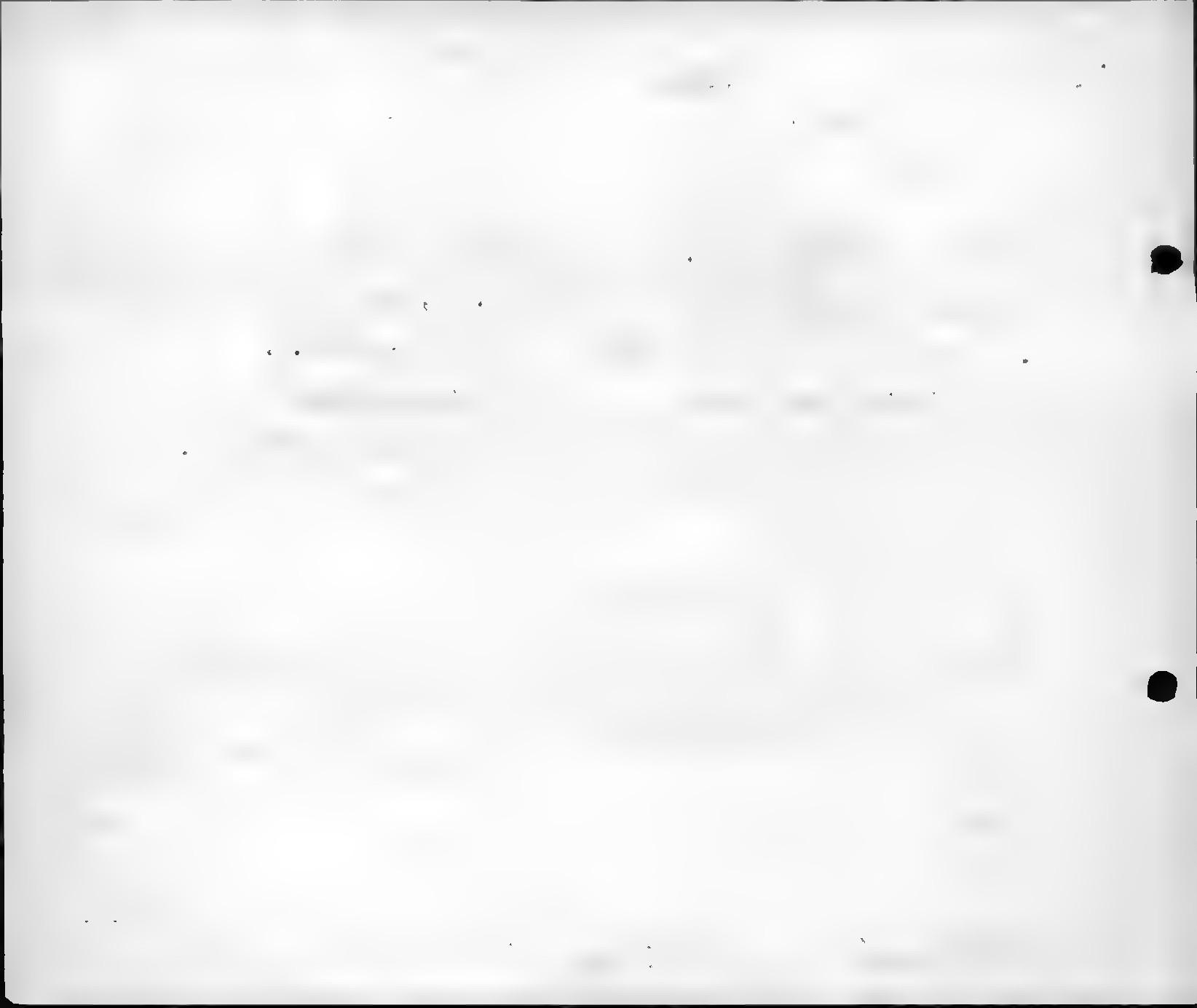
1756 Pa. Ave. Wash., D. C.

24a. REC'D BY REGISTRAR

FEB 16 '60

24b. REGISTRAR'S SIGNATURE

Cathleen S. Kraus



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

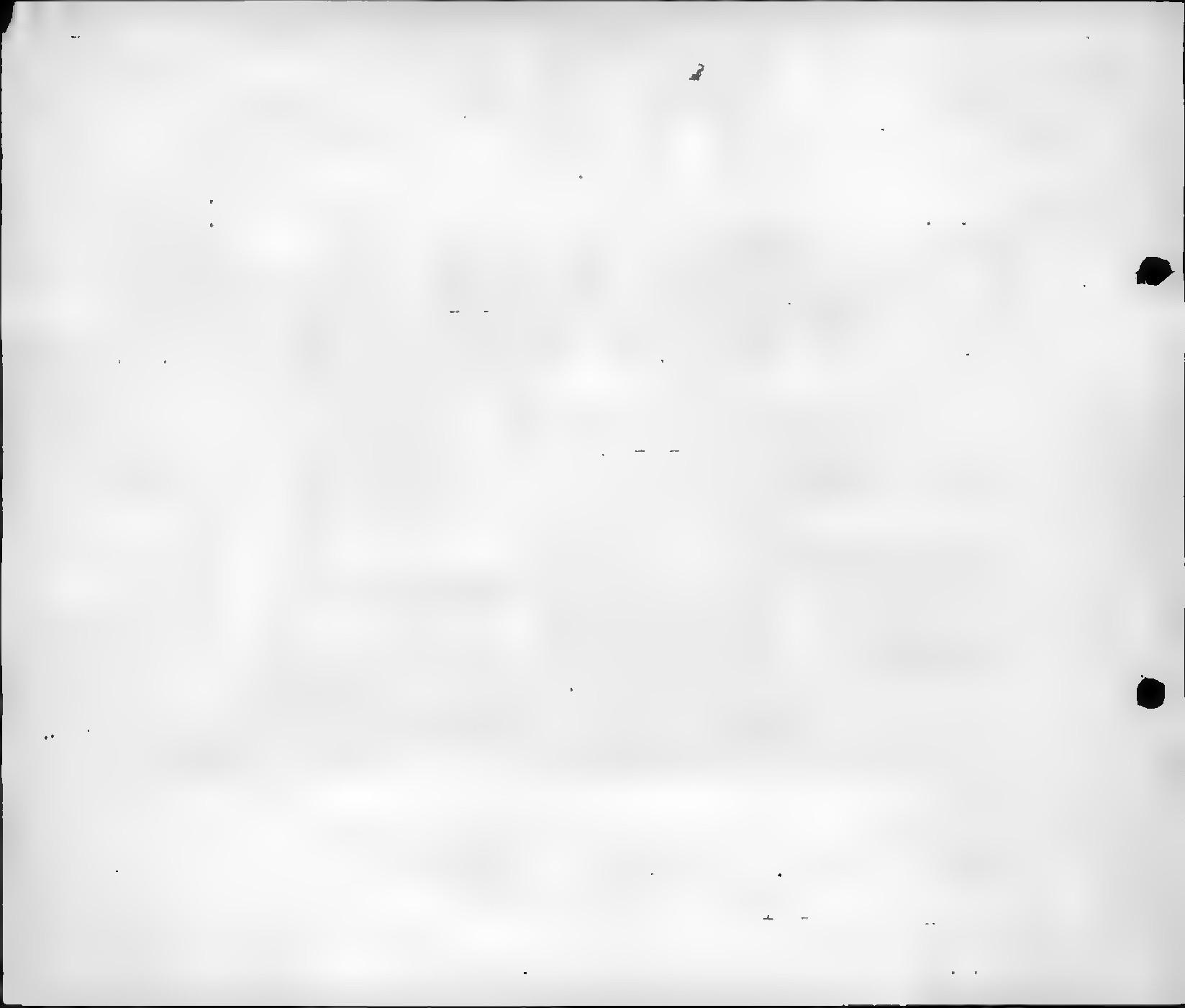
02174

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM2. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 215

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2227 | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | a. STATE Indiana | | b. COUNTY | | | |
| Bethesda (Rural) | | 13 hrs. | | Marion | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 1815 Miller Ave. | | IS PERSON E ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| U. S. Naval Hospital | | | | F15 Fairfield Trailer Ct. | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Lionel | Middle Vernon | HUSTON | 4. DATE OF DEATH | Month February | Day 18 | Year 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 10-23-34 | 9. AGE (In years last birthday) 25 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Mariner | | 11. BIRTHPLACE (State or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John David Huston | | | | 14. MOTHER'S MAIDEN NAME Helen Mae Adams | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 1952 to DOD | | 17. INFORMANT Hospital Records | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage | | | | | | | | | |
| 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Fracture of skull 27 hours | | | | | | | | | |
| DUE TO (c) Multiple injuries extreme | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in pvt. auto which skidded off road and struck tree | | | | | | | | | |
| 20c. TIME OF INJURY Hour 1:40 | | Month, Day, Year 2/17 1960 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Route 222 near Bainbridge Md Lancaster Pa. | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2-18-60 | | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | | | | | | |
| 22e. BURIAL, CREMATION REMOVAL (Specify) Burial-Shipment | | 22f. DATE THEREOF 2-19-60 | | 22g. NAME OF CEMETERY OR CREMATORIUM Garden of Memories | | 22h. LOCATION (City, town, or county) Marion | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>We Chambers by S. J. Broschart</i> | | ADDRESS W.H. Chambers Funeral Home, 1400 Chapin St. N.W. | | WashDC | | 24e. REC'D. BY REGISTRAR FEB 23 '60 | | 24b. REGISTRAR'S SIGNATURE <i>S. J. Broschart</i> | |
| VS. A15ME SM 2/57 | | | | | | | | | |



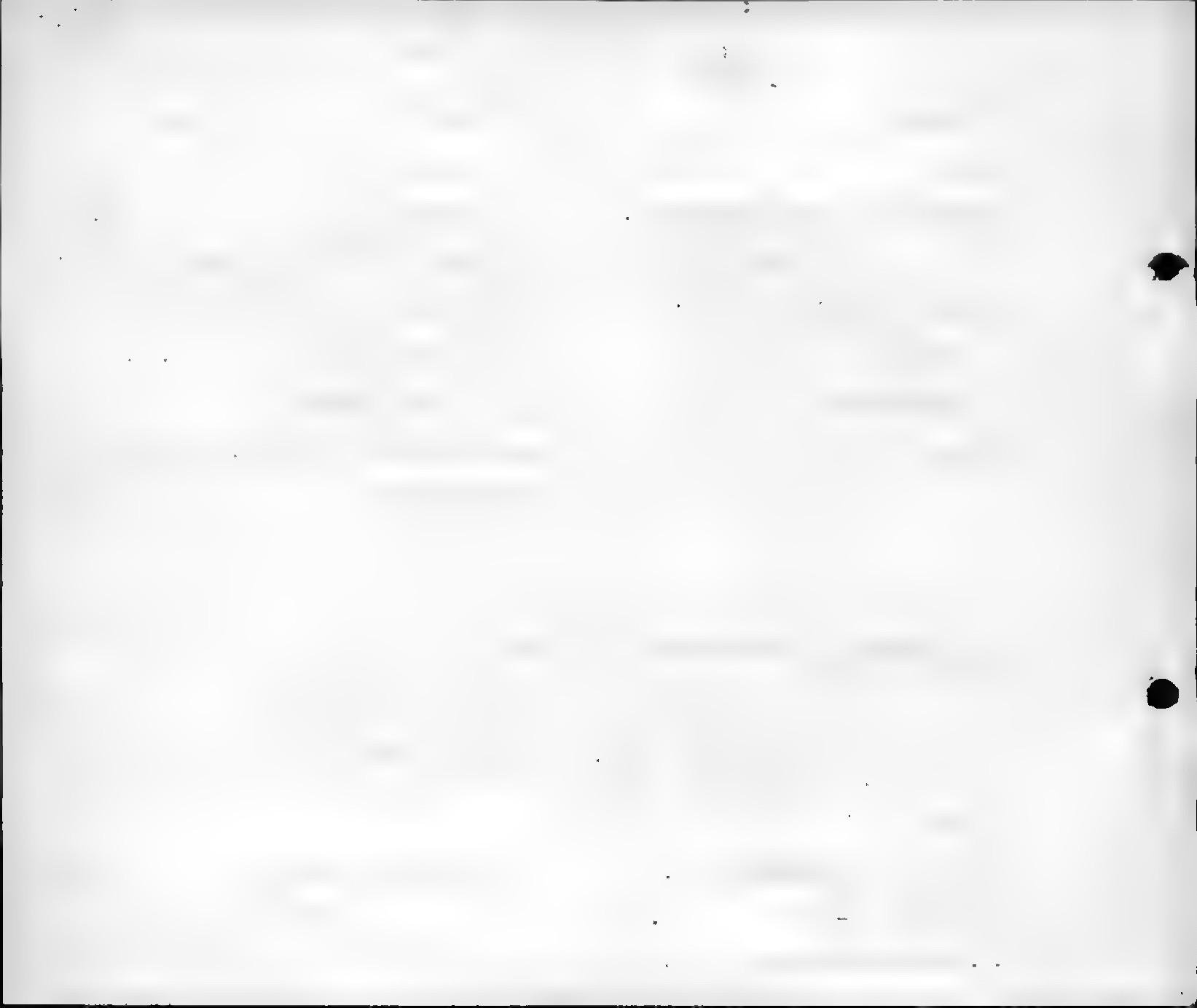
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02175

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clerksville | |
| 3. NAME OF DECEASED (Type or print) Mary | | d. STREET ADDRESS Hall Shop Road | |
| 4. DATE OF DEATH Lager | | Month February | Day 10 |
| 5. SEX Female | | Age (In years last birthday) 79 yrs | Year 1960 |
| 6. COLOR OR RACE White | | IF UNDER 1 YEAR Months 79 | IF UNDER 24 HRS Hours 2 days |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/12/1880 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Igleshart | | 14. MOTHER'S MAIDEN NAME Mary Harding | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Hospital Records | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | |
| | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19. MEDICAL CERTIFICATION | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial failure 10 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 1, 1960 to Feb. 10, 1960 , that I last saw the deceased alive on Feb. 9, 1960 , and that death occurred at 7 AM , from the causes and on the date stated above ACTUAL SIGNATURE Charles S. Whitaker M.D. | | 22. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 2/10/60 | |
| 23. PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D. | | 24a. REC'D BY REGISTRAR DATE FEB 15 '60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-13-60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's | | 22d. LOCATION (City, town, or county) Fulton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

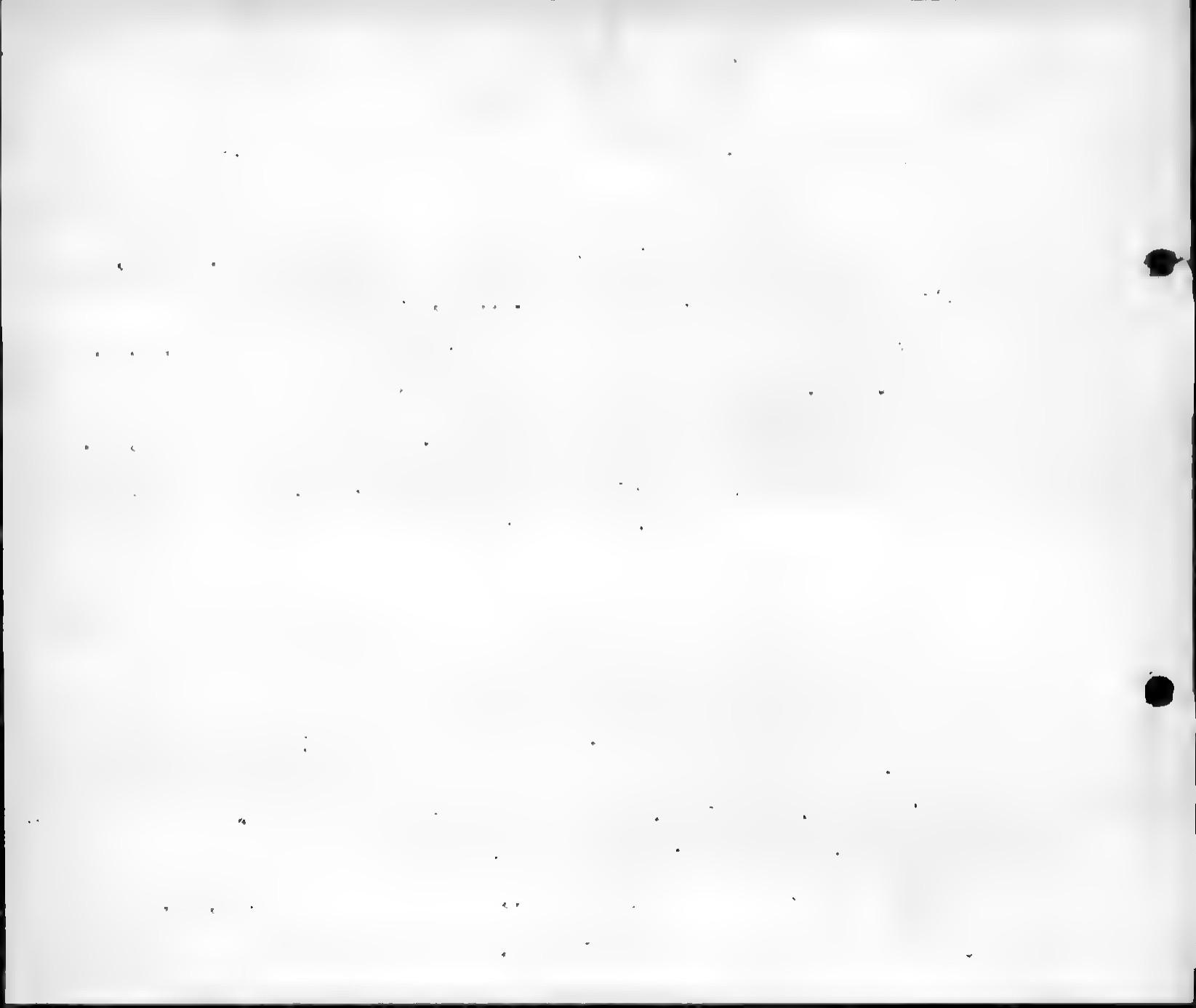
02176

2229

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (Rural) | | | | c. LENGTH OF STAY IN Tb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg (Rural) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First JOHN | Middle CLINTON | Last IMES | 4. DATE OF DEATH Month Feb. | Day 21 | Year 19 60 |
| 5. SEX male | | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 12, 1899 | 9. AGE (In years last birthday) 60 yrs. | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John W. Imes | | | | 14. MOTHER'S MAIDEN NAME Bertie Thomas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | INFORMANT Katherine R. Dyson | | Address Gaithersburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Duodenal Ulcer DUE TO 541.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diiodinal Ulcer DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3.7.60 , 19 60 , to FEB. 21 , 19 60 , that I last saw the deceased alive on FEB. 20 , 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE William Frank PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D. ADDRESS (Street, city or town, state) 544 W MONTGOMERY AVE. DATE SIGNED 2/23/60 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/24/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Poplar Grove, | | 22d. LOCATION (City, town, or county) Poplar Grove, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Snodder | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 25 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |

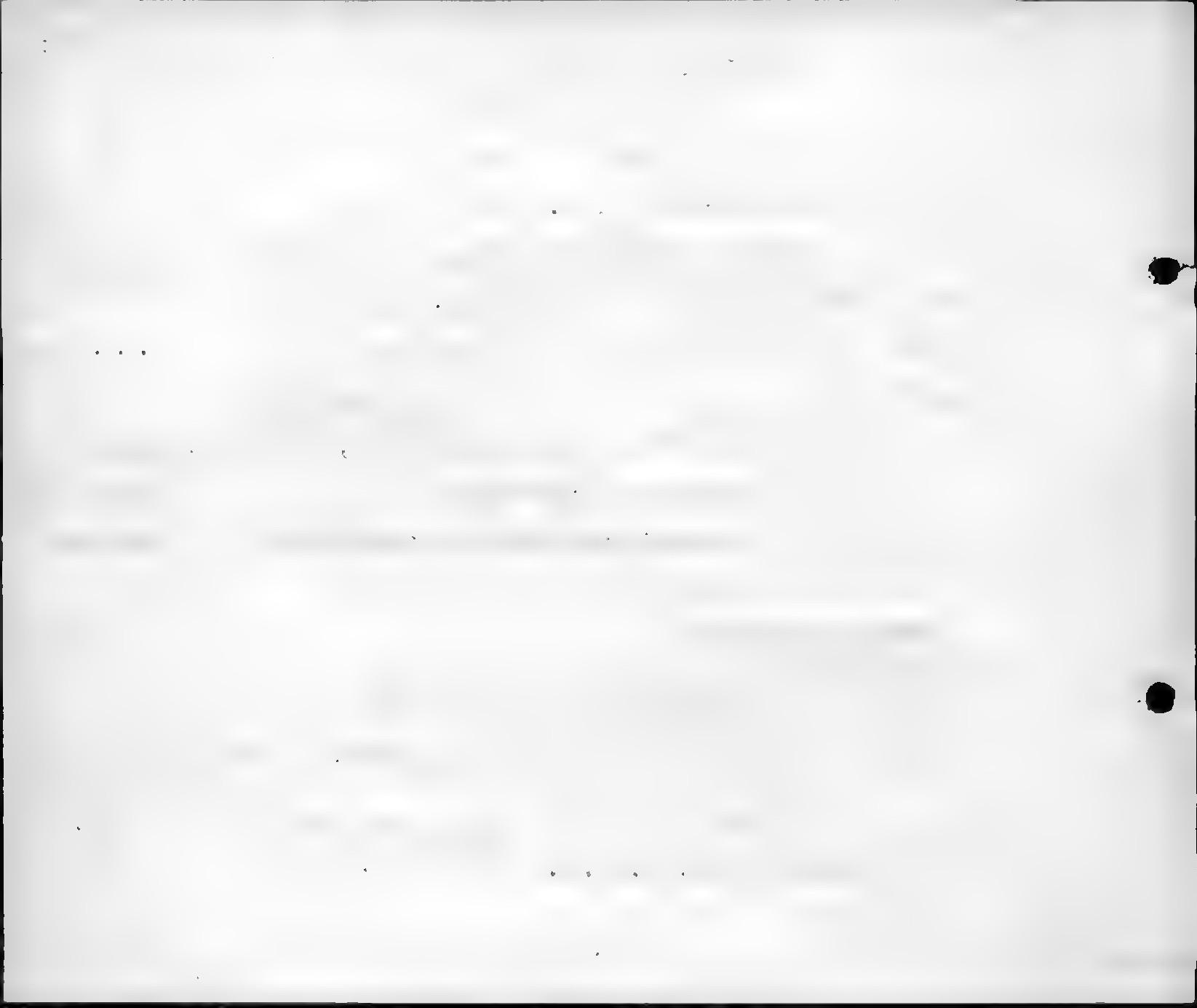


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02177

| | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE New York | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn | | d. STREET ADDRESS 1611 49th Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Phyllis | Middle (None) | Last Iozzia | 4. DATE OF DEATH February | Month 8 | Day 19 | Year 60 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 15, 1949 | 9. AGE (In years last birthday) 10 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS Hours 0 | Year Min. 0 |
| 10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Iozzia | | 14. MOTHER'S MAIDEN NAME Louise Raffaniello | | | | | |
| 15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO (If yes, give war or date of service) None | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO 1950 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma of the adrenal cortex DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic decompensation | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm factory street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from February 7, 1960 , to February 8, 1960 , that I last saw the deceased alive on February 8, 1960 , and that death occurred at 3:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John Leeman Lewis Jr.</i> M.D. The Clinical Center 2/8/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN LEEMAN LEWIS, JR., M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 10, 1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM U.S. NATIONAL | | 22d. LOCATION (City, town, or county) LONG ISLAND N.Y. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi Funeral Home, 816 N. Fine, Jr.</i> | | ADDRESS <i>Rinaldi Funeral Home, 816 N. Fine, Jr.</i> | | 24a. REC'D BY REGISTRAR DATE FEB 9 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kraus</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

IF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C2178

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Maryland Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Olney</i> | | c. LENGTH OF STAY IN 16 30 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery County General Hospital</i> | | e. STREET ADDRESS Rt. #2 | |
| 3. NAME OF DECEASED (Type or print) <i>John</i> | | 4. DATE OF DEATH February 21 19 60 | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 1881 | | 9. AGE (In years last birthday) 79 yrs | |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | |
| 13. FATHER'S NAME <i>Albert Johnson</i> | | 14. MOTHER'S MAIDEN NAME <i>Priscilla Jackson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT <i>Florance Johnson Rt. #2, Rockville, Md.</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>Pulmonary Embolism</i> | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 464x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). (b) <i>Broncho Phlebothrombosis</i> (c) <i>Bronchopneumonia & abscesses</i> | | Z-3 weeks. 4-6 weeks. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1/21/60</i> , 19, to <i>2/1/60</i> , 19, that I last saw the deceased alive on <i>2/20/60</i> , 19, and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Norbeck, Md.</i> DATE SIGNED <i>2/22/60</i> | |
| ACTUAL SIGNATURE <i>Richard A. Yates, M.D.</i> | | PHYSICIAN'S NAME (Type) <i>Richard A. Yates, M.D.</i> | |
| 22a. BURIAL, CREMATON REMOVAL (Specify) Burial 2/25/60 | | 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Pleasant,</i> | |
| 22d. LOCATION (City, town, or county) <i>Norbeck, Md.</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Shandling</i> | | 24a. REC'D BY REGISTRAR FEB 25 '60 | |
| ADDRESS <i>Rockville, Md.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hinman</i> | |

✓

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached and removed from the certificate. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director after death.

VS A15 15M 9/52

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

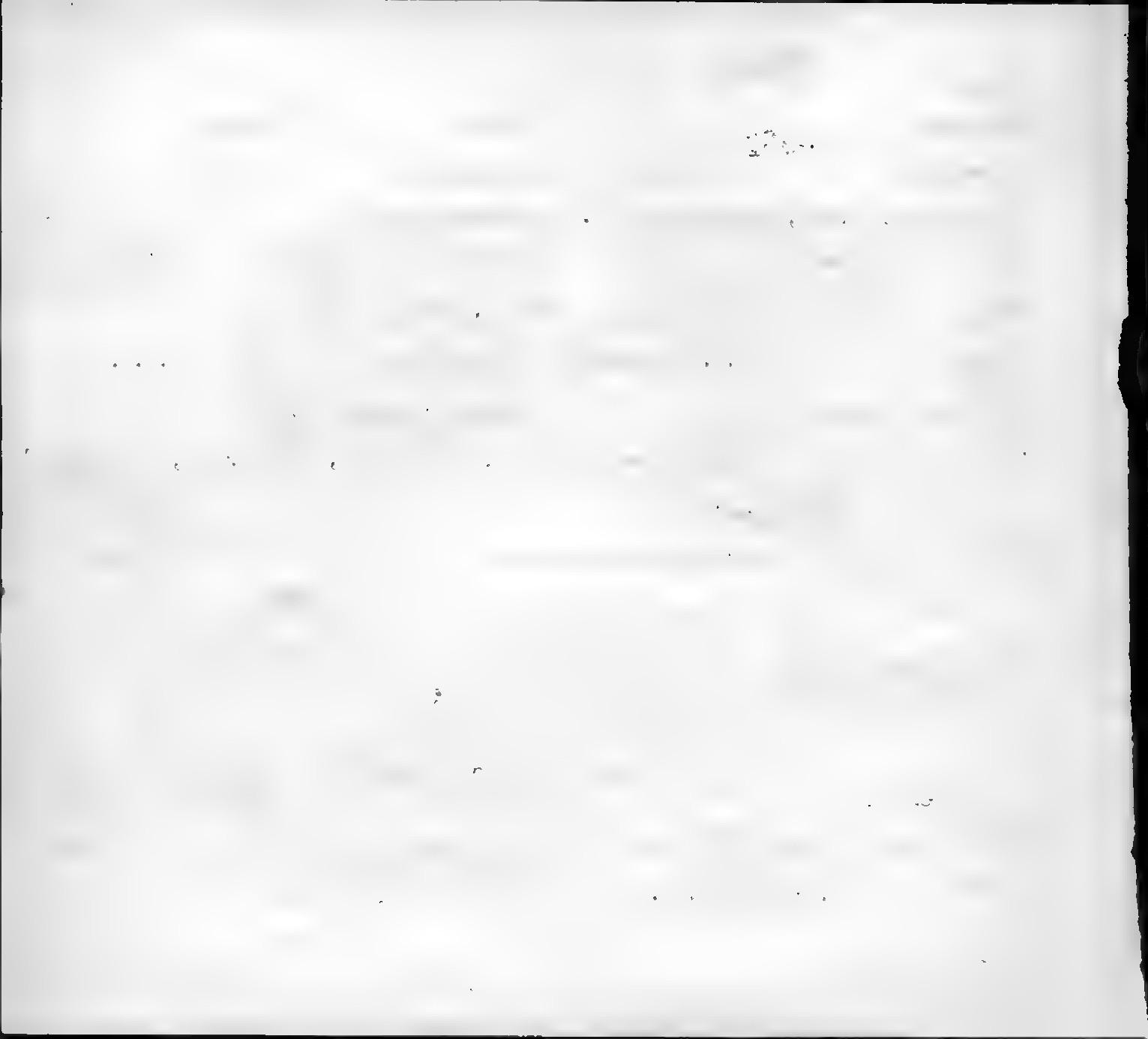
02179

3580

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|---------------------------------------|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia | | b. COUNTY Fairfax | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 50 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church | | d. STREET ADDRESS 508 Faber Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Charles | Middle Arthur | Last Johnstone | 4. DATE OF DEATH February 29 | Month | Day | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH June 3, 1907 | 9. AGE (In years last birthday) 52 | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS Hours 12 | Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Washington | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Carl Otto Johnstone | | | | 14. MOTHER'S MAIDEN NAME Amanda Swenson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hremia DUE TO 200.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Reticulum cell sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH Days 1 year | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from January 10, 1960 , to February 29, 1960 , that I last saw the deceased alive on February 29, 1960 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harold J. Fallon M.D. 3/1/60 PHYSICIAN'S NAME (Type) HAROLD J. FALLON, M. D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/3/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens | | 22d. LOCATION (City, town, or county) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mac A. Thomas Arlington Funeral Home | | ADDRESS 3901 North Fairfax Dr. | | 24a. REC'D BY REGISTRAR MAR 3 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |
| Arlington, Va. | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 File # G258 3-7-60 et

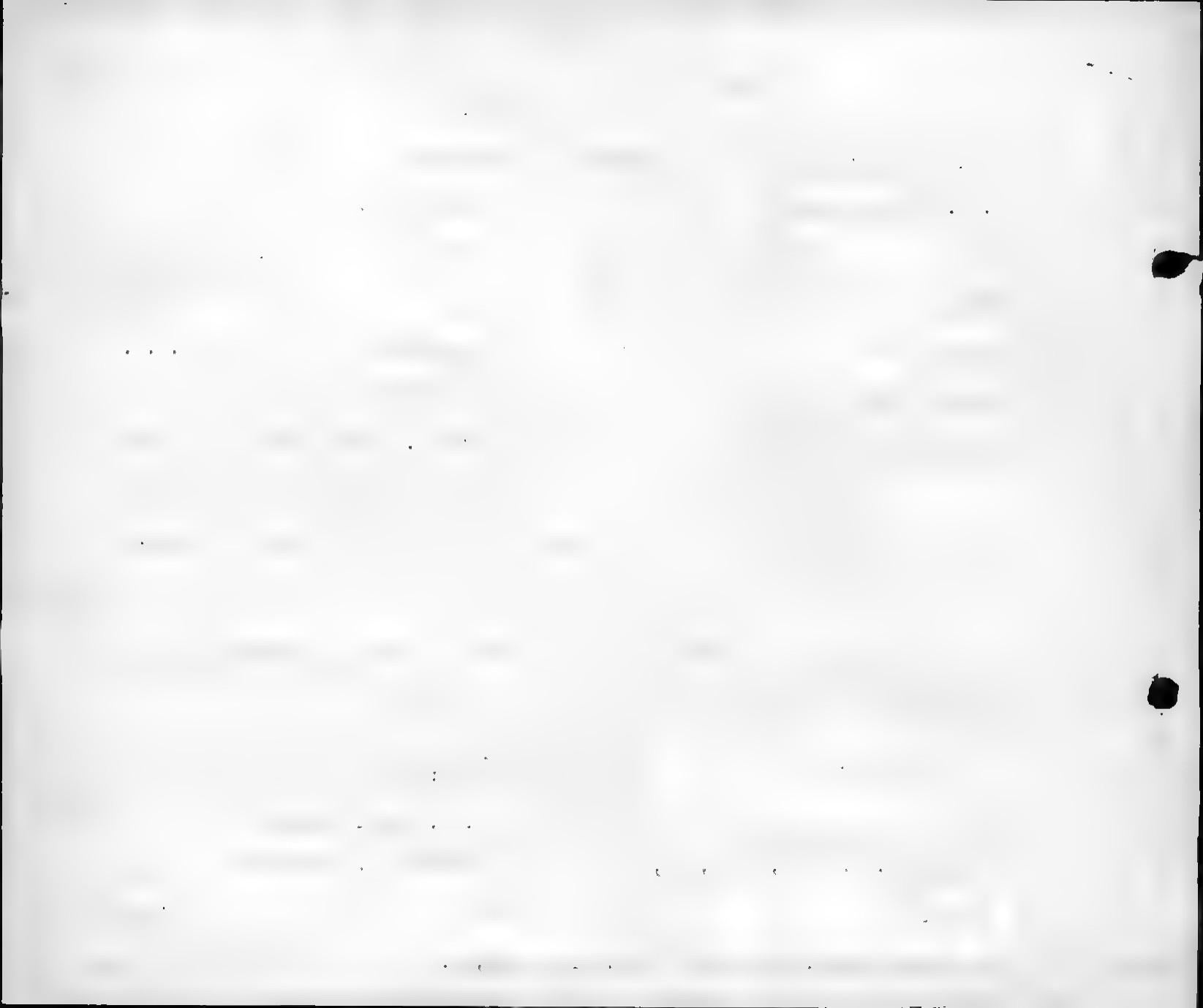
02180

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|---|---|---|---|--|
| PLACE OF DEATH a. COUNTY Montgomery | | 2232 MARYLAND | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 87 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | d. STREET ADDRESS 215 Thor Drive | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Jo-An | Middle Ellen | Lost JONES | 4 DATE OF DEATH Month February Day 19 Year 1960 |
| 5. SEX Female | 6 COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B DATE OF BIRTH 11-9-32 | 9 AGE (In years lost birthday) 27 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Wisconsin | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Ralph JONES | | 14. MOTHER'S MAIDEN NAME Ellen ERNST | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes 1951 to 1953 | | 16. SOCIAL SECURITY NO INFORMANT | Address (H) Laverne L. Jones, same as #2 above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x <i>cerebral thrombosis and infarction</i> INTERVAL BETWEEN ONSET AND DEATH 2 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>anterior communicating artery (cerebral)aneurysm</i> 2 mos (c) ----- | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) U. S. Naval Hospital | (County) (State) |
| 21. I certify that I attended the deceased from November 24, 1959, to February 19, 1960, that I last saw the deceased alive on February 19, 1960 , and that death occurred at 10:40A M, from the causes and on the date stated above | | | | |
| ACTUAL SIGNATURE <i>M. W. Wood MD</i> | | ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 2-20-60 | | |
| PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-23-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington | (State) Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va.</i> | | 24a. REC'D BY REGISTRAR FEB 24 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233 CERTIFICATE OF DEATH

Reg. Dist. No. 215

02181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|--|---|---|---|--|--|-------------------------------------|---------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE North Carolina | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Lejeune | | d. STREET ADDRESS MEMQ 1221, Air Facility | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Karen | | First | Middle | Last | 4. DATE OF DEATH JONES | Month | Day | Year |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 12-13-59 | 9. AGE (In years last birthday) yrs. 2 | IF UNDER 1 YEAR Months 2 | IF UNDER 24 HRS Days 3 | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Thomas Semmes JONES | | | 14. MOTHER'S MAIDEN NAME Irene KNIGHTON | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT Hospital Records | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. cardiac arrest | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) endocardial fibroelastosis DUE TO congenital mitral and aortic stenosis 2 months aspiration pneumonia | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1.5 hours | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from February 3, 1960 , to February 16, 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 1:51 P.M. from the causes and on the date stated above. | | | | | | | | |
| ADDRESS (Street, city or town state) U. S. Naval Hospital DATE SIGNED 2-16 59 | | | | | | | | |
| ACTUAL SIGNATURE John H. Mazur | | | | | | | | |
| PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Shipment 22b. DATE THEREOF 2-18-60 22c. NAME OF CEMETERY OR CREMATORY Bethesda 14, Maryland 22d. LOCATION (City, town, or county) (State) Memphis Tennessee | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kress ADDRESS S. H. HINES CO., 2901 14th St., NW, Washington DC 24a. REC'D BY REGISTRAR FEB 18 '60 24b. REGISTRAR'S SIGNATURE | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2142

CERTIFICATE OF DEATH

Reg. Dist. No.

02182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|--|--|---|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Maryland</i> | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <i>MARYLAND</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Washington, D.C. 3109 Beech St., N.W.</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eventide - 700 Hudson Av.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <i>MARGARET Elizabeth Jones</i> | First <i>Margaret</i> | Middle <i>Elizabeth</i> | Last <i>Jones</i> | |
| 4. DATE OF DEATH <i>Feb 1, 1960</i> | Month <i>Feb</i> | Day <i>1</i> | Year <i>1960</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-16-1878</i> | |
| 9. AGE (In years last birthday) <i>81 yr.</i> | | 10. IF UNDER 1 YEAR Months <i>0</i> | | |
| 11. IF UNDER 24 HRS Days <i>0</i> | | 12. IF UNDER 24 HRS Hours <i>0</i> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) Frederick Co., Md.</i> | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>Jacob Monroe EYLER</i> | 14. MOTHER'S MAIDEN NAME <i>Margaret Elizabeth Stamp</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO <i>081-12-0000</i> | 17. INFORMANT <i>Gladys Wakefield, 700 Hudson Takoma Park</i> | Address <i>one</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Bacterial Hypertension</i> DUE TO <i>Mediastinal</i> | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>one week</i> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Generalized arterio-sclerosis of small vessels</i> | | | | |
| 20c. TIME OF INJURY Hour o.m. _____ p.m. _____ | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10620 Georgia Lane</i> | (County) <i>Montgomery</i> | (State) <i>Maryland</i> |
| 21. I certify that I attended the deceased from <i>Jan 20, 1960</i> , to <i>Feb 1, 1960</i> , that I last saw the deceased alive on <i>Jan 21, 1960</i> , and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>George L. Ball, M.D.</i> | | | | |
| ADDRESS (Street, city or town, state) <i>10620 Georgia Lane, Silver Spring, Md.</i> | | | | |
| DATE SIGNED <i>Feb 1, 1960</i> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2/3/1960</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Salem Cemetery</i> | 22d. LOCATION (City/town, or county) <i>Brookville</i> | (State) <i>Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i> | ADDRESS <i>4600 Liberty Hghts. Ave.</i> | 24a. REC'D BY REGISTRAR <i>ER 2 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Wm. S. Kline</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

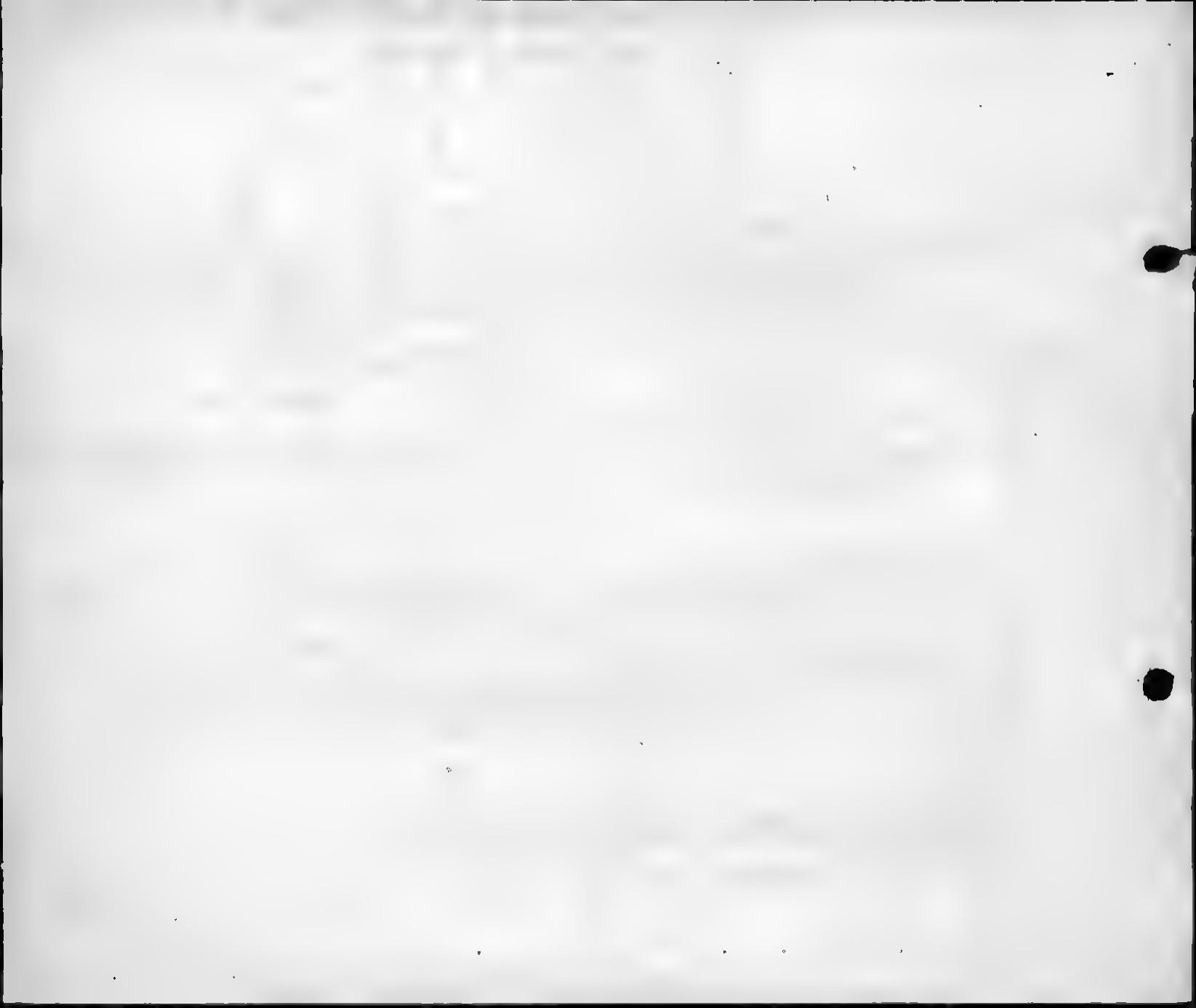
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2234

CERTIFICATE OF DEATH

Reg. Dist. No. 02183

| | | | | | | | |
|--|--|---|---|--|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>D.C.</i> | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i> | | c. LENGTH OF STAY IN 1b 6 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47x</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Found. INC</i> | | | | d. STREET ADDRESS <i>1920 S. St. N.W.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Rizie</i> | | First <i>S.</i> | Middle <i>KELLY</i> | 4. DATE OF DEATH <i>Feb 2 1960</i> | Month <i>Feb</i> | Day <i>2</i> | Year <i>1960</i> |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 27 1875</i> | 9. AGE (In years last birthday) <i>84 yrs</i> | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>David L. Gibson</i> | | 14. MOTHER'S MAIDEN NAME <i>Connie</i> | | DUN BAR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>Carl Kelly 3201 Dowell Rd Silver Spring</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Virus Influenza</i> INTERVAL BETWEEN THE ONSET AND DEATH <i>2 days</i> | | | | | | | |
| 4. x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last | | DUE TO (b) <i>Frost left Femur (neck)</i> | | 2 weeks | | | |
| | | DUE TO (c) <i>Dr. Carl Siberis + Sonally</i> | | 10 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>2 Jan</i> , 19 <i>60</i> , to <i>2 Feb</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2 Feb</i> , 19 <i>60</i> , and that death occurred at <i>1308 M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | | | |
| ACTUAL SIGNATURE <i>John Bosley Zeigler</i> | | DATE SIGNED <i>2 Feb 60</i> | | | | | |
| PHYSICIAN'S NAME (Type) <i>JOHN BOSLEY ZEIGLER</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>2/5/60</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>GATE OF HEAVEN CEMETERY</i> | | 22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> | | ADDRESS <i>SILVER SPRING, MD.</i> | | 24a. REC'D BY REGISTRAR <i>DATE FEB 4 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] a. STATE MARYLAND | | b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN lb 7 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | | d. STREET ADDRESS 4505 SIGSBEE ROAD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN | | First EDWARD Middle KEMP | | 4. DATE OF DEATH FEBRUARY 2 1960 | | Month Day Year | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/28/03 | |
| 9. AGE (In years last birthday) 56 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC | | 10b. KIND OF BUSINESS OR INDUSTRY TRANSIT CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME EDWARD W. KEMP | | 14. MOTHER'S MAIDEN NAME MARGARET LOUISE DAY | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No | |
| 16. SOCIAL SECURITY NO. Unknown | | INFORMANT HOSPITAL RECORDS | | Address OLNEY, Mo. | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli (massive) DUE TO 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). Prostatic veins Thrombosis DUE TO (b) (c) Pneumonia edema | |
| 18. INTERVAL BETWEEN ONSET AND DEATH | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Years , 19 57 , to Feb 2 , 19 60 , that I last saw the deceased alive on 2/2 , 19 60 , and that death occurred at 9:30 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Lewis L. Leal</i> | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) L. L. LEAL, M. D. | | GAITHERSBURG, MARYLAND | | | | | |
| 22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial Feb 6 1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak | | 22d. LOCATION (City, town, or county) Gaithersburg Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Amir H Barber</i> | | ADDRESS Laytonsville, Md | | 24a. REC'D BY REGISTRAR DATE FEB 5 '60 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traud</i> | | | |



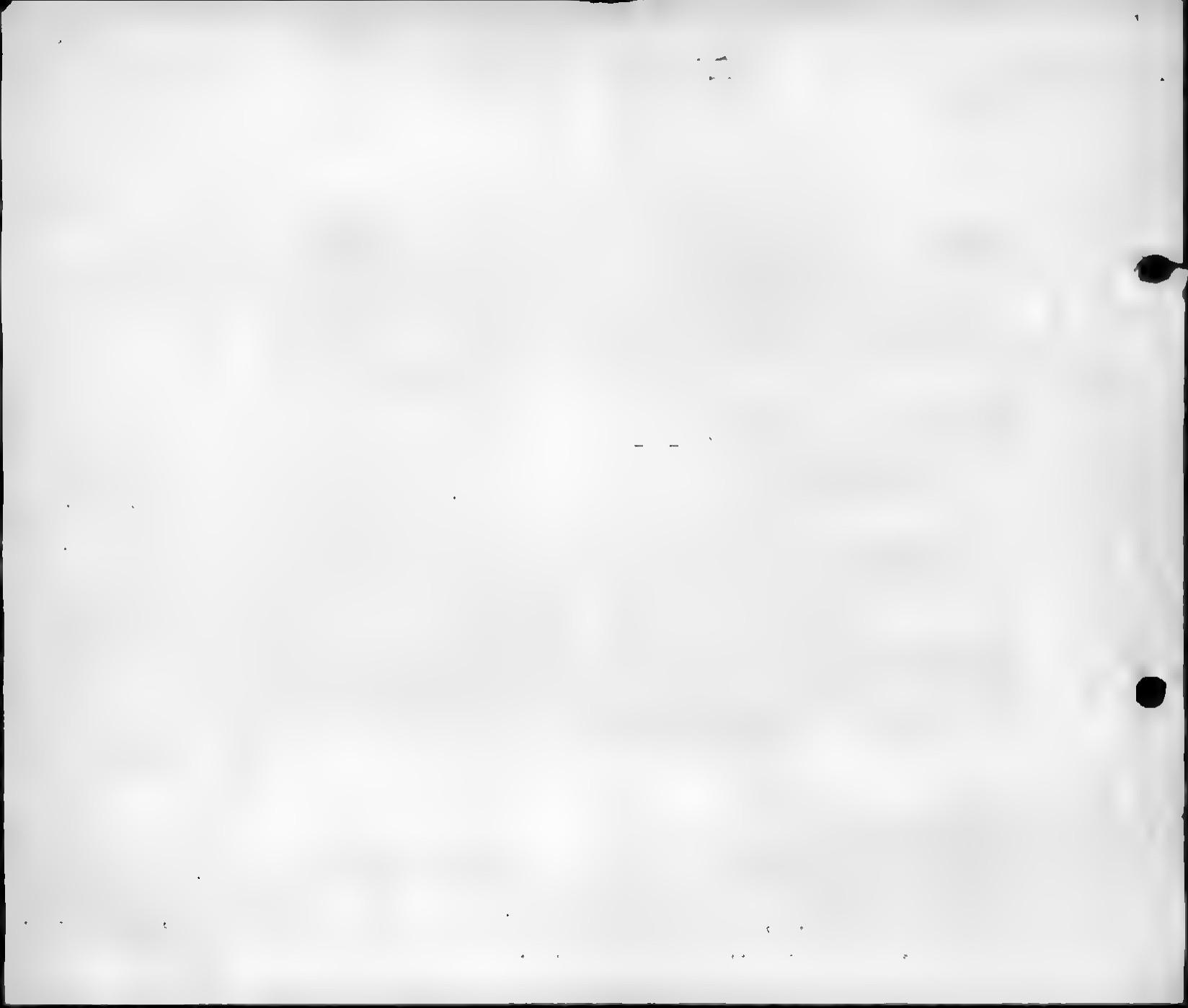
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02185**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. A certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2143 | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md. | | c. LENGTH OF STAY IN 16 20 days | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Home | | e. STREET ADDRESS 406 Dale Drive | | e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Nora Alice Kemp | | First | Middle | Last | 4. DATE OF DEATH 2 - 1 - 1960 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-17-74 | 9. AGE (in years last birthday) 65 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Produce | | 11. BIRTHPLACE (State or foreign country) Georgia | |
| 13. FATHER'S NAME Warren Watson | | 14. MOTHER'S MAIDEN NAME Martha Taylor | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 257-50-2481 | | 17. INFORMANT Address Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 DUE TO Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Bronchitis pneumonia DUE TO Fracture of ribs (left) 10 days | | | | | |
| DUE TO (c) Fracture of ribs (left) 27 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell down stair step at home | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 8 o m 1-4 1960 | | 20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) Silver Spring | (County) Maryland (State) MD |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Frank J. Blaschke | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED Feb 1 1960 | |
| EXAMINER'S NAME (Type) FRANK J. Blaschke | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 4, 1960 | | 22c. NAME OF CEMETERY OR CREMATORIAL MIDWAY CHURCH CEMETERY | |
| 22d. LOCATION (City, town, or county) NEAR LOST MOUNTAIN, MARIETTA, GA. | | (State) GA. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR Feb 3 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2144

CERTIFICATE OF DEATH

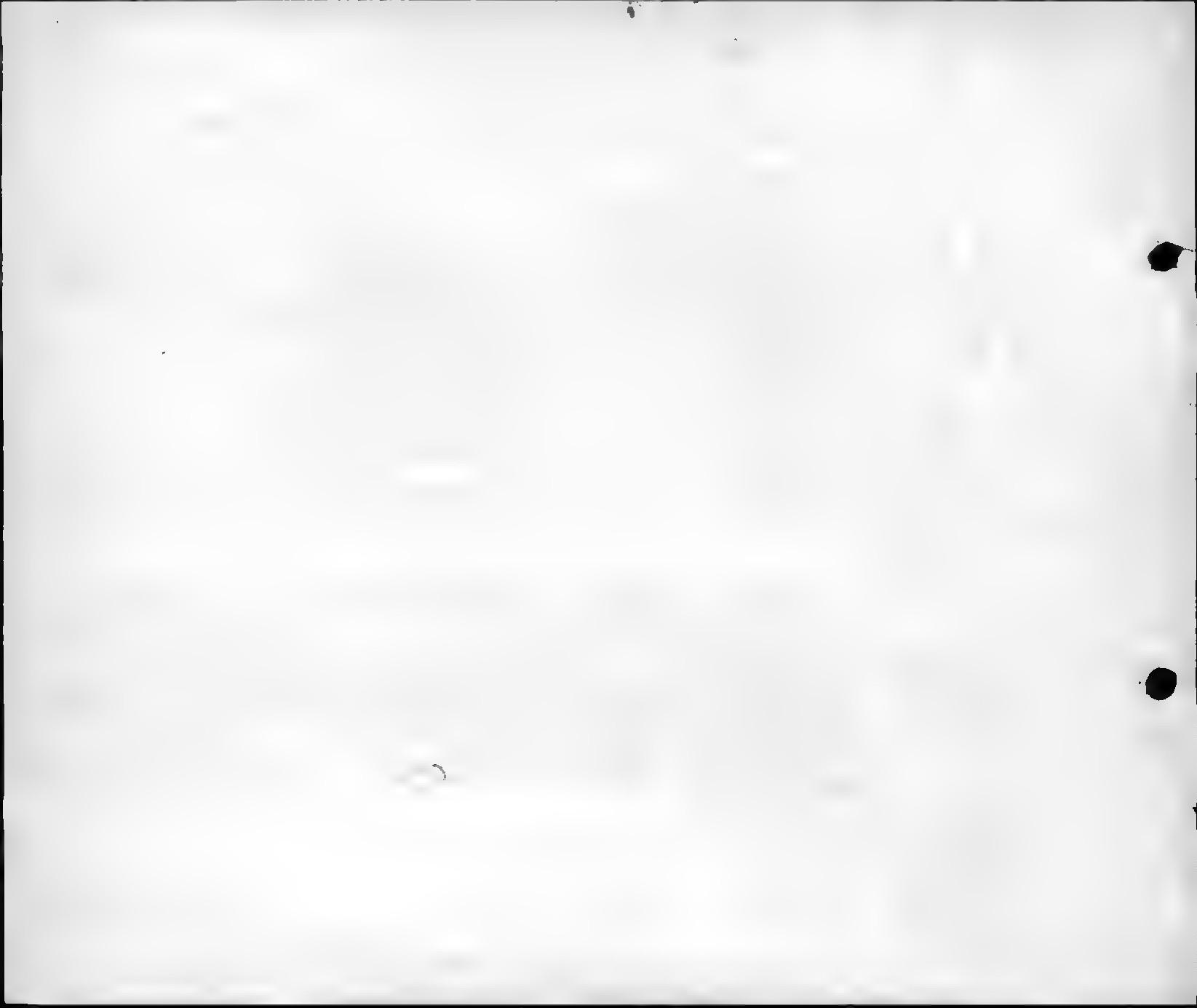
Reg. Dist. No.

102186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | c. LENGTH OF STAY IN lb | b. COUNTY <i>Montgomery</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i> | d. STREET ADDRESS <i>7503 Flower Ave.</i> | e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>William Daniel Kimble</i> | First <i>W</i> | Middle <i>D</i> | Last <i>Kimble</i> | | |
| 4. DATE OF DEATH <i>Feb 2 1960</i> | Month | Day | Year | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>June 29, 1876</i> | 9. AGE (In years last birthday) <i>83 yrs.</i> | IF UNDER 1 YEAR Months <i>0</i> | IF UNDER 24 HRS Hours <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>N.Y.</i> | 12 CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | |
| 13. FATHER'S NAME <i>James D. Kimble</i> | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Lane</i> | | Address <i>Hospital Records</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. | INFORMANT | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>one day</i> | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal Bleeding</i> | | | one week. | | |
| DUE TO (c) <i>Intestinal Obstruction + toxicity</i> | | | one month | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Feb 2 1960</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Takoma Park</i> | (County) <i>Maryland</i> |
| 21. I certify that I attended the deceased from <i>Mar 1959</i> to <i>Feb 2 1960</i> , that I last saw the deceased alive on <i>Feb 2 1960</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>Robert A Hare</i> | | M.D. <i>Robert A Hare, MD</i> | | ADDRESS (Street, city or town, state) <i>Takoma Park Md.</i> DATE SIGNED <i>2/3/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Robert A Hare</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Feb 6, 1960</i> | | | |
| 22b. DATE THEREOF <i>Feb 6, 1960</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Maryland Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>New York State</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Wattis, 254 Carroll St NW DC</i> | | ADDRESS <i>254 Carroll St NW DC</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 5 '60</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2145

CERTIFICATE OF DEATH

Reg. Dist. No.

02187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---------------------------------|---|-----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> | | b. COUNTY <i>Prince Georges</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>8 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> | | d. STREET ADDRESS <i>1903 Erie St Apt 102</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i> | | | | e. DATE OF DEATH <i>February 7 1960</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Claydys</i> | Middle <i>Bailey</i> | Last <i>King</i> | Month <i>February</i> | Day <i>7</i> | Year <i>1960</i> | |
| 4. SEX <i>fe</i> | 6. COLOR OR RACE <i>Cauc</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-9-93</i> | 9. AGE (In years last birthday) yrs. <i>67</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | Days <i>0</i> | IF UNDER 24 HRS Hours <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> | | 11. BIRTHPLACE (State or foreign country) <i>South Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Wm Bailey</i> | | 14. MOTHER'S MAIDEN NAME <i>Emily E. Gregorie</i> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | INFORMANT <i>Hospital Record</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>ventilatory collapse.</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 hours.</i> | | | | | | | |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>urebral hemorrhage.</i> 8 days. (c) <i>cerebral arteriosclerosis.</i> indefinite | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1-30-1960</i> to <i>2-7-1960</i> that I last saw the deceased alive on <i>2-7-1960</i> , and that death occurred at <i>6:40 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <i>Silver Spring, Md.</i> DATE SIGNED <i>2-7-60.</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Seruch T. Kimble.</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF <i>2/10/60</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i> | | 22d. LOCATION (City, town or county) (State) <i>MONTGOMERY COUNTY, MD.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey, Inc.</i> | | | | ADDRESS <i>SILVER SPRING, MD.</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Curtis S. Kraus</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

214S CERTIFICATE OF DEATH

Reg. Dist. No.

02188

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville | | d. STREET ADDRESS 2123 Guilford Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Krieg Baby Boy | | First | Middle | Last | 4. DATE OF DEATH Month 2 Day 24 Year 1960 | Month | Day | Year | |
| 5. SEX Boy | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/22/60 | | 9. AGE (in years less birthday) yrs 2 | 10. IF UNDER 1 YEAR Months 2 | 11. IF UNDER 24 HRS Hours 2 | 12. IF UNDER 24 HRS Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Norbert Jack Krieg | | 14. MOTHER'S MAIDEN NAME Ingeborg Wildruth Koeppel | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Mother - 2123 Guilford Road | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity | | DUE TO 776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) | | DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/> 19 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2123 Guilford Road | | 20f. (City or town) Bethesda | | (County) Montgomery | (State) Md. |
| 21. I certify that I attended the deceased from 2:20 pm Feb 22 1960 to 2/24 1960 , that I last saw the deceased alive on 2/24 1960 , and that death occurred at 8:30 p.m. from the causes and on the date stated above | | | | | | ADDRESS (Street, city or town, state) 8224 Georgia Ave., S.S., Md. | | DATE SIGNED 2/25/60 | |
| ACTUAL SIGNATURE H.H. Diamond | | M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) H. H. Diamond, M.D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF Feb. 25 | | 22c. NAME OF CEMETERY OR CREMATORIAL Washington Sanitarium & Hospital, Takoma Park, Md. | | 22d. LOCATION (City, town, or county) Takoma Park, Md. | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Washington San. & Hosp. | | ADDRESS | | 24a. REC'D BY REGISTRAR FR 29 1960 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02189

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | |
| f. STREET ADDRESS Laplates Indian Head | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | h. DATE 08X-2 Month 2 Day 18 Year 1960 | |
| 3. NAME OF DECEASED (Type or print) Joseph William Kronk | | 4. DATE OF DEATH Last | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> August 16, 1873 | |
| 9. AGE (In years last birthday) 86 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 86 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Louis M. Kronk | | 14. MOTHER'S MAIDEN NAME Elizabeth Barnes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. Spanish-American War none | |
| 17. INFORMANT Carlin M. Cronk, 10 First St., Indianhead, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO 40 INTERVAL BETWEEN ONSET AND DEATH 15 hrs | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 40 (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/1/60 , 1960, to 2/18/60 , 1960, that I last saw the deceased alive on 2/18/60 , 1960, and that death occurred at 12:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE S. D. Bognard | | ADDRESS (Street, city or town, state) Sandy Spring, Md., 2/18/60 | |
| PHYSICIAN'S NAME (Type) A. D. Bonapart, M.D. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/21/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Park Hill Cemetery | | 22d. LOCATION (City, town, or county) Marbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arnhart Funeral Home, Inc., LaPlata, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 23 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2237 CERTIFICATE OF DEATH

Reg. Dist. No. (12191)

| | | | | | | |
|--|-------------------------|---|---|---|--------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | | | |
| <i>Montgomerys.</i> MARYLAND | | Wash. D.C. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| Bethesda | | Washington D.C. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| <i>Westmorelawn</i> | 3815 Calvert St. | | | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | | | |
| RACHEL | L | | LAMBERT | | | |
| 4. DATE OF DEATH | Month | Day | Year | | | |
| | 2 | 20 | 1960 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years from birthday) 96 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 10/3/1863 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| <i>Hank wife</i> | | — | | MARYLAND | | U.S.A. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | |
| <i>Roland, John</i> | | <i>Lockhart, Mary</i> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address |
| No | | | | No | | HERROY R. Sweetman |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | |
| <i>Myocardial Failure</i> | | | | | | |
| DUE TO | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>423.1</i> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | |
| DUE TO | | | | | | |
| (b) <i>Atrialricular fibrillation</i> | | | | | | |
| DUE TO | | | | | | |
| (c) <i>Sinus Eelectic myocarditis</i> | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> | | | | | | |
| 20a. MEDICAL CERTIFICATION | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 6 a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3141-3859, NW | | (County) (State) |
| 21. I certify that I attended the deceased from <i>Decemb</i> 1948 to <i>Feb. 20, 1960</i> , that I last saw the deceased alive on <i>Feb. 19, 1960</i> , and that death occurred at <i>9:50 AM</i> , from the causes and on the date stated above | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | |
| ACTUAL SIGNATURE <i>J. E. Johnson Jr.</i> | | | | | | |
| PHYSICIAN'S NAME (Type) <i>James A. GANNON</i> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>2-22-60</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wilson L. Ebel</i> | | ADDRESS <i>2224 N. Lincoln Rd., B.C.</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 23 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. Ebel</i> |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12191

| | | | |
|---|--------------------------------|--|-------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| Montgomery | | a. STATE | Maryland |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN lb | b. COUNTY | Montgomery |
| Cherry Chase Md. | years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Cherry Chase, Md. |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS | | |
| 7105 46th St., Chevy Chase, Md. | 7105 46th St., Chevy Chase Md. | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | 4. DATE OF DEATH |
| Frances | L | Mary | Month 2 Day 7 Year 1960 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | April 18, 1866 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Housewife | | None | |
| 10c. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Wash. D.C. | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| John McCrister | | Frances M. Byrne | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 17. INFORMANT | |
| d. No | | None Katherine Hutchinson, Daughter Chevy Chase, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | Address 7105 46th St., | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 351X | | 2 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | year | |
| (b) DUE TO | | Generalized arteriosclerosis | |
| (c) DUE TO | | | |
| (d) DUE TO | | | |
| (e) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>Frank J. Borschert</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>Frank J. Borschert</i> | | 2-8-60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/9/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery | | 22d. LOCATION (City, town, or county) Washington, D. C. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | | ADDRESS | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <i>Collier & Farrel</i> | |
| DATE FEB 9 '60 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02193

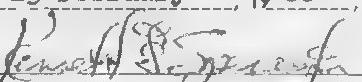
2238 CERTIFICATE OF DEATH

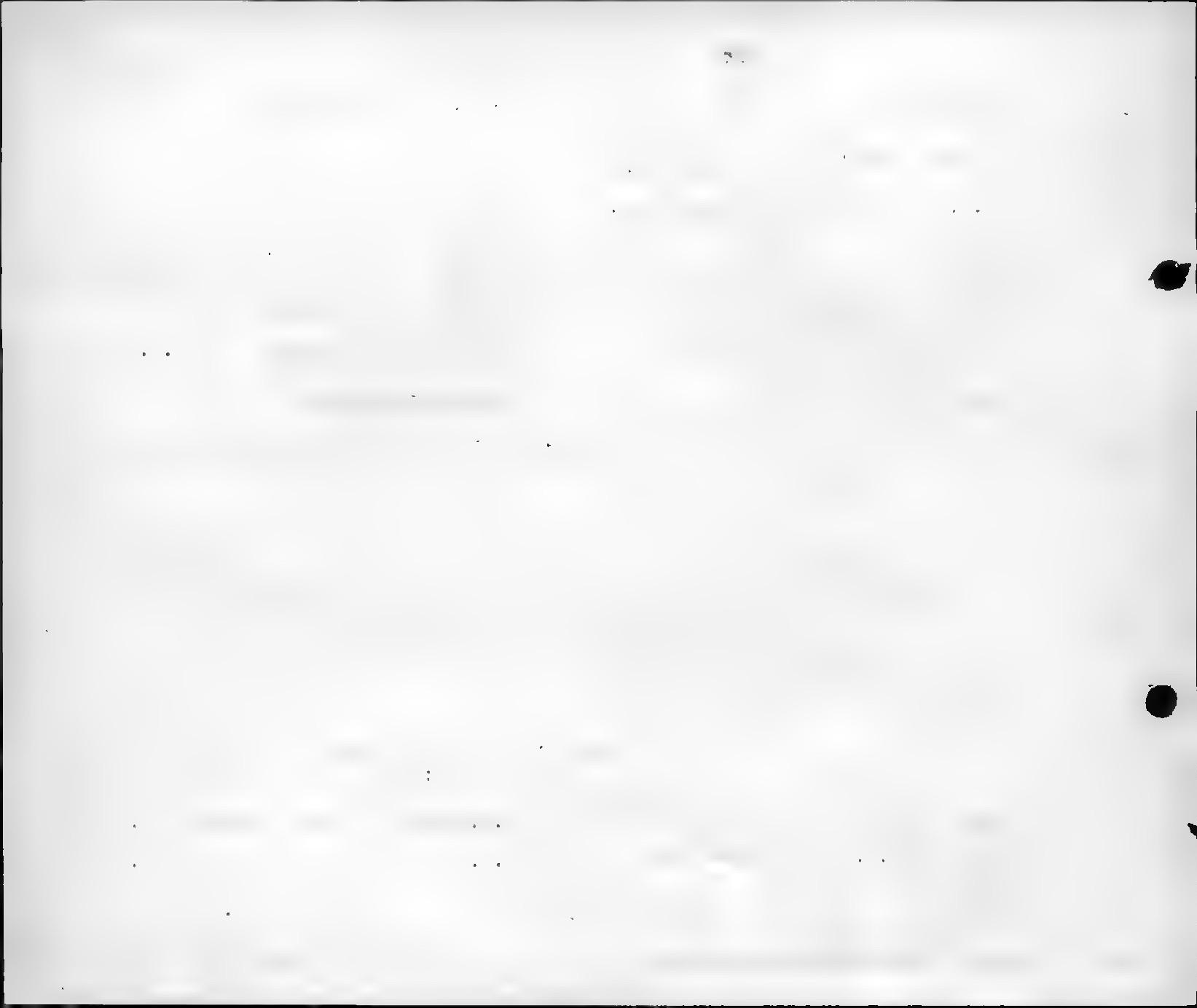
Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| | | | | | |
|---|---|---|--|---|--|
| 1. PLACE OF DEATH COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If inst. name: Residence before admission) STATE District of Columbia | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c LENGTH OF STAY IN Tb 14 Days | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | d STREET ADDRESS 1555 Fort Dupont Street SE | |
| e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Ida | Middle Mae | Last LEDOUX | 4. DATE OF DEATH | Month February Day 23 Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-4-64 | 9. AGE (In years last birthday) 95 yrs | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) District of Columbia | |
| 13. FATHER'S NAME John HOWE | | 14. MOTHER'S MAIDEN NAME Frances ROBERTSON | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| IS WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT (Son) Lenderville LEDOUX | Address Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X | | | | | |
| DUE TO Pneumonia | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fracture/simpler right hip (c) general old age and debility | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 February , 1960, to 23 February , 1960, that I last saw the deceased alive on 23 February , 1960, and that death occurred at 12:12 P.M. , from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-23-60 | | | | | |
| ACTUAL SIGNATURE  | | | | | |
| PHYSICIAN'S NAME (Type) K.F. SPENCE LT MC USN | | | | | |
| U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-26-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | | 22d. LOCATION (City, town, or county) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee's 4th & Massachusetts Ave NW WDC | | | ADDRESS | | 24a. REC'D. BY REGISTRAR FEB 29 '60 |
| | | | | | 24b. REGISTRAR'S SIGNATURE C. L. Haase |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2147 CERTIFICATE OF DEATH

Reg. Dist. No. 02194

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN lb <i>25 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Harry</i> | Middle <i>Merle</i> | Last <i>Lerch, SR</i> |
| 4. DATE OF DEATH | Month <i>Feb</i> | Day <i>25</i> | Year <i>1960</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-22-93</i> |
| 9. AGE (In years lost, birthday) <i>67 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>6</i> | 11. IF UNDER 24 HRS. Days <i>7</i> | Hours <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Print Leader</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gove. Printing Office</i> | |
| 10c. BIRTHPLACE (State or foreign country) <i>Pa.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>EDWARD P. Lerch</i> | | 14. MOTHER'S MAIDEN NAME <i>Amanda Young</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>213-38-3503</i> | |
| 17. INFORMANT <i>W.S. Hospital Records</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | |
| 42.1 DUE TO <i>Myocardial infarction</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | | |
| (b) DUE TO <i>Coronary Occlusion</i> | | | |
| (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>24 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Oct 8 6</i> , 1957, to <i>Feb 25, 1960</i> , that I last saw the deceased alive on <i>Feb 24, 1960</i> , and that death occurred at <i>9:25 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Merrill M. Cross</i> | | ADDRESS (Street, city or town, state) <i>8248 Georgia Ave. 2/25/60</i> | |
| PHYSICIAN'S NAME (Type) <i>MERRILL M. CROSS</i> | | DATE SIGNED <i>2/25/60</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Checkmark) ENTOMBMENT <i>2/29/60</i> | | 22b. DATE THEREOF <i>2/29/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN MAUSOLEUM</i> | | 22d. LOCATION (City, town, or county) <i>PRINCE GEO. COUNTY, MARYLAND</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY INC.</i> | | ADDRESS <i>SILVER SPRING, MD.</i> | |
| 24a. REC'D BY REGISTRAR <i>FEB 29 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>C. Knapp</i> | |

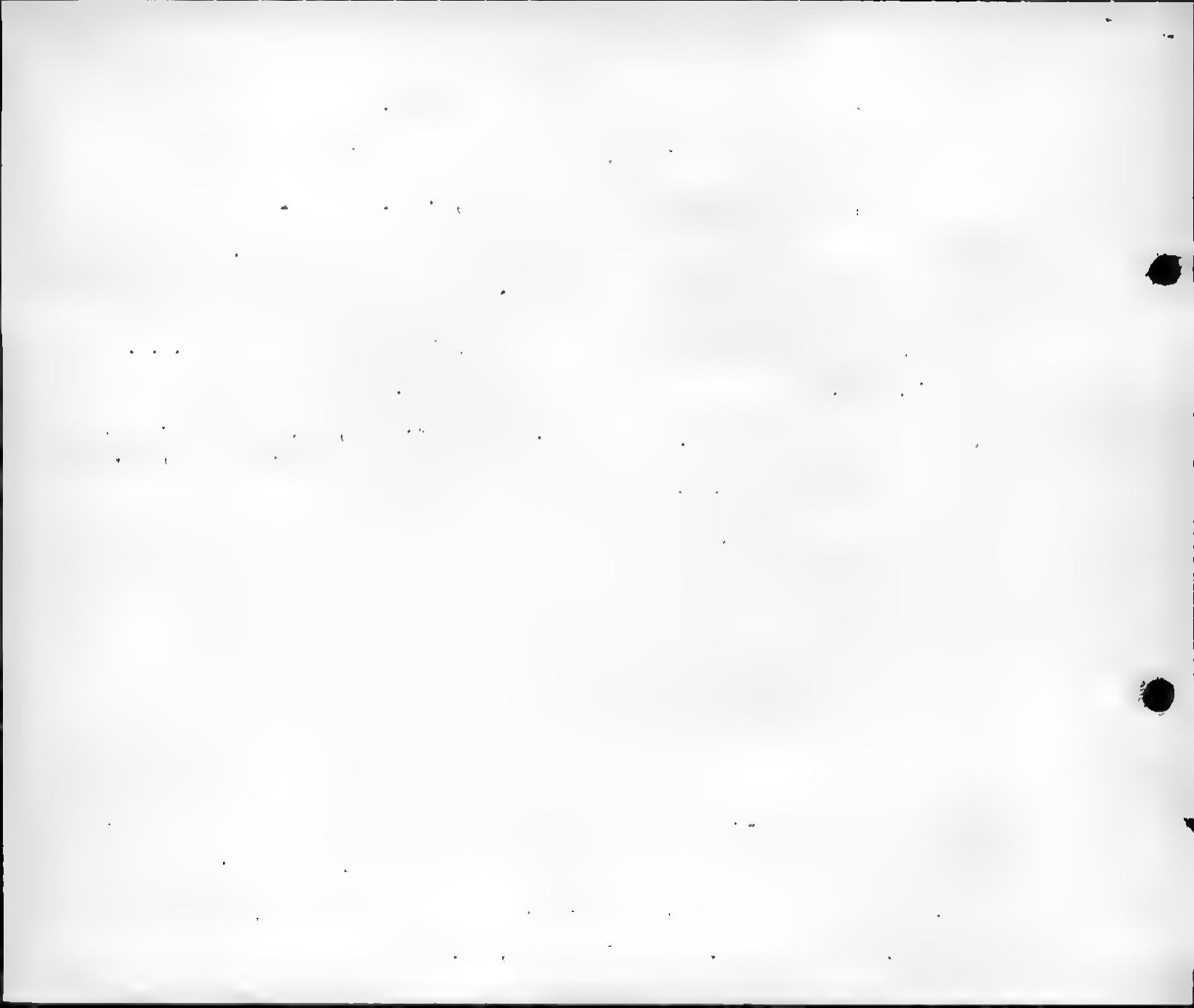


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2121 CERTIFICATE OF DEATH

02196

Reg. Dist. No.

| | | | | | |
|--|--|--|---|--|---|
| 1. PLACE OF DEATH o COUNTY MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c LENGTH OF STAY IN 1b 8 yrs. | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,903 Hathaway Drive | | | d. STREET ADDRESS 12,903 Hathaway Drive | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First CARRIE | Middle BELLE | Last LEWIS | 4. DATE OF DEATH FEB. 23 |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/24/66 | 9. AGE (In years last birthday) 93 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME ROBERT M. DAWSON | | 14. MOTHER'S MAIDEN NAME ROBERTA C. MINTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | INFORMANT Mrs. Estelle Hodgson, 12,903 Hathaway Drive Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | | INTERVAL BETWEEN ONSET AND DEATH Myocardial Failure 2 days | | | |
| Died X Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause first. | | (b) DUE TO Hypostatic Pneumonia 2 days | | | |
| (c) DUE TO Senility | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/26, 1956, to 2/23, 1960, that I last saw the deceased alive on 1/1, 1960, and that death occurred at 12:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE N.T. LUCIUS | | M.D. 9321 Georgia Ave Silver Spring, Md. | | | |
| PHYSICIAN'S NAME (Type) N.T. LUCIUS | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/26/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL UNION CEMETERY | |
| 22d. LOCATION (City, town, or county) ALEXANDRIA, VIRGINIA | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Arthur S. Kraus | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE FEB 25 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172 CERTIFICATE OF DEATH

Reg. Dist. No.

02195

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | 2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>WASH. D. C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosemont</u> | | c. LENGTH OF STAY IN 1b <u>12 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosemont Gardens SAN</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x 3</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence E. L'Hommedieu</u> | | d. STREET ADDRESS <u>2942 NEWARK ST. N.W.</u> | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-20-1872</u> | |
| 9. AGE (In years last birthday) <u>87 yrs.</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>60</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Waitress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wm Coenwell</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Regaway</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no unknown) <u>No</u> | | 16. SOCIAL SECURITY NO <u>578-10-1697</u> | |
| 17. INFORMANT <u>Mr. Samuel J. L'Hommedieu</u> | | Address <u>2739 McKinley St NW</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO <u>Hypertension</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> | | 12 months | |
| DUE TO <u>Arteriosclerosis</u> | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>decubital ulcers, senility</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>DC</u> | |
| 21. I certify that I attended the deceased from <u>Feb. 2</u> , 1960, to <u>Feb. 2</u> , 1960, that I last saw the deceased alive on <u>2 February</u> , 1960, and that death occurred at <u>1240 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph H. Cowan</u> | | ADDRESS (Street, city or town, state) <u>4817 Lennox Av. NW Wash 8 DC</u> | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH H. COWAN</u> | | DATE SIGNED <u>2/2/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/5/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <u>Angel Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Harrow Le Grace Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chevy Chase Funeral Home Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>John de Grace</u> | |
| ADDRESS <u>5103 Wisconsin</u> | | 24b. REGISTRAR'S SIGNATURE <u>John de Grace</u> | |
| DATE <u>2/8/60</u> | | CITY <u>Washington</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2239

CERTIFICATE OF DEATH

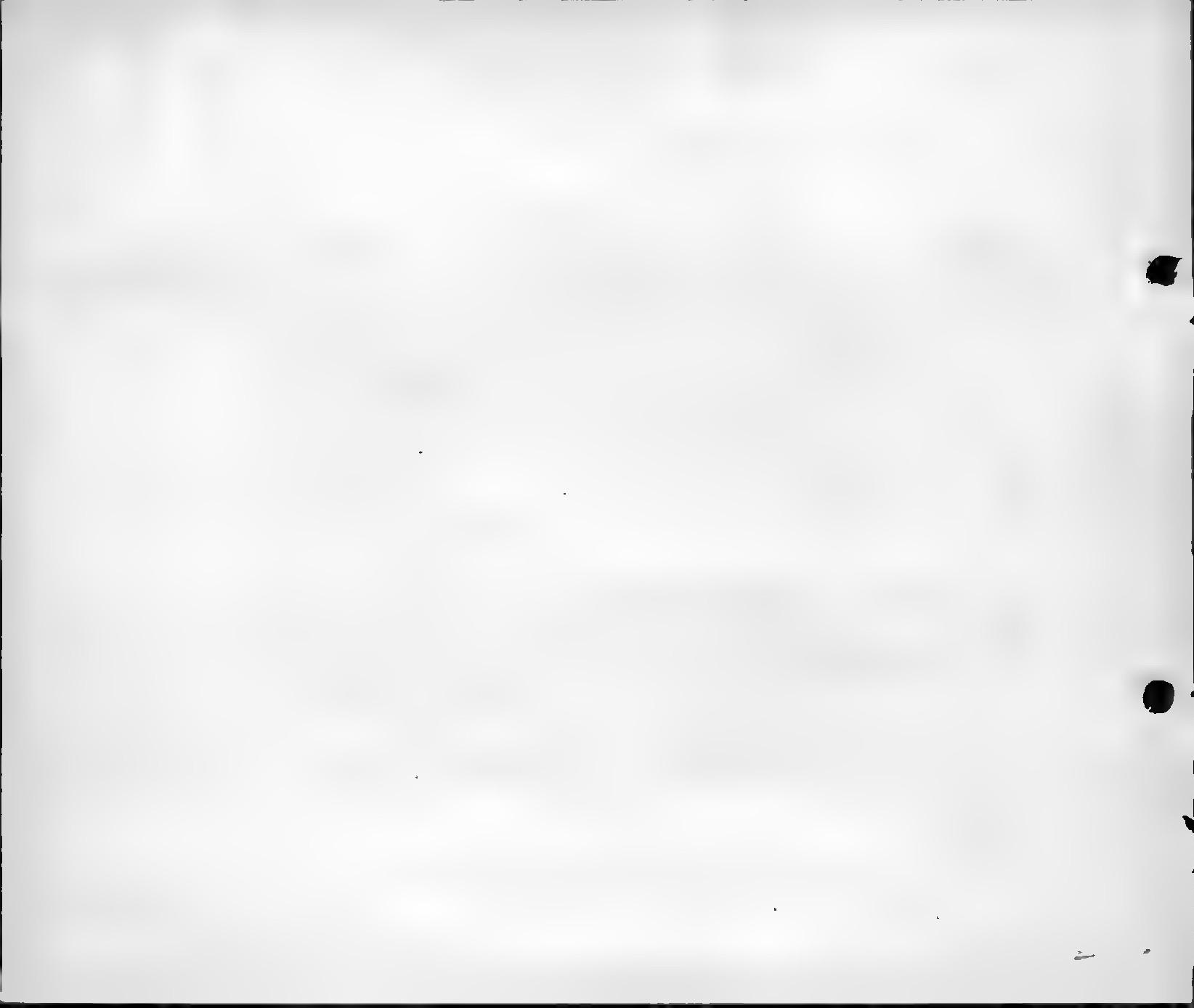
Reg. Dist. No.

02197

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Maryland</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i> | | c. LENGTH OF STAY IN 1b <i>6 mos</i> | |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5651 Lee Spring</i> | | e. STREET ADDRESS <i>1111 Lee Spring</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Sophia</i> | Middle <i>M.</i> | Last <i>Lee</i> |
| 4. DATE OF DEATH | Month <i>Sept</i> | Day <i>18</i> | Year <i>1960</i> |
| 5. SEX | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 18, 1882</i> |
| 9. AGE (In years lost birthday) yrs. <i>78</i> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i> | Days <i>0</i> | Hours <i>0</i> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 12. KIND OF BUSINESS OR INDUSTRY <i>-</i> | 13. BIRTHPLACE (State or Foreign country) <i>Germany</i> | 14. CITIZEN OF WHAT COUNTRY <i>Germany</i> |
| 15. FATHER'S NAME <i>Hugh August</i> | 16. MOTHER'S MAIDEN NAME <i>-</i> | 17. INFORMANT <i>Mrs. P.M.C. 111 Lee Spring</i> | |
| 18. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture left femur</i> DUE TO <i>Varicose Veins (Epidemic)</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture left femur</i> DUE TO <i>Varicose Veins (Epidemic)</i> 3 weeks | | | |
| (c) <i>Gen. aut. Sclerosis + Senility</i> 8 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Olney Md</i> |
| 20f. (City or town) <i>Olney</i> | | (County) <i>Md</i> | |
| (State) <i>Md</i> | | | |
| 21. I certify that I attended the deceased from <i>13 Feb</i> , 1960, to <i>8 Feb</i> , 1966, that I last saw the deceased alive on <i>8 Feb</i> , 1960, and that death occurred at <i>7:00 AM</i> , from the causes and on the date stated above | | | |
| ADDRESS (Street, city or town, state) <i>Olney Md</i> DATE SIGNED <i>8 Feb 60</i> | | | |
| ACTUAL SIGNATURE <i>John Booley Ziegler M.D.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>JOHN BOOLEY ZIEGLER</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Feb 10, 1960</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect Hill Cemetery</i> | 22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walter, 254 Carroll St NW DC</i> | ADDRESS <i>254 Carroll St NW DC</i> | 24a. REC'D BY REGISTRAR DATE <i>FEB 10 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

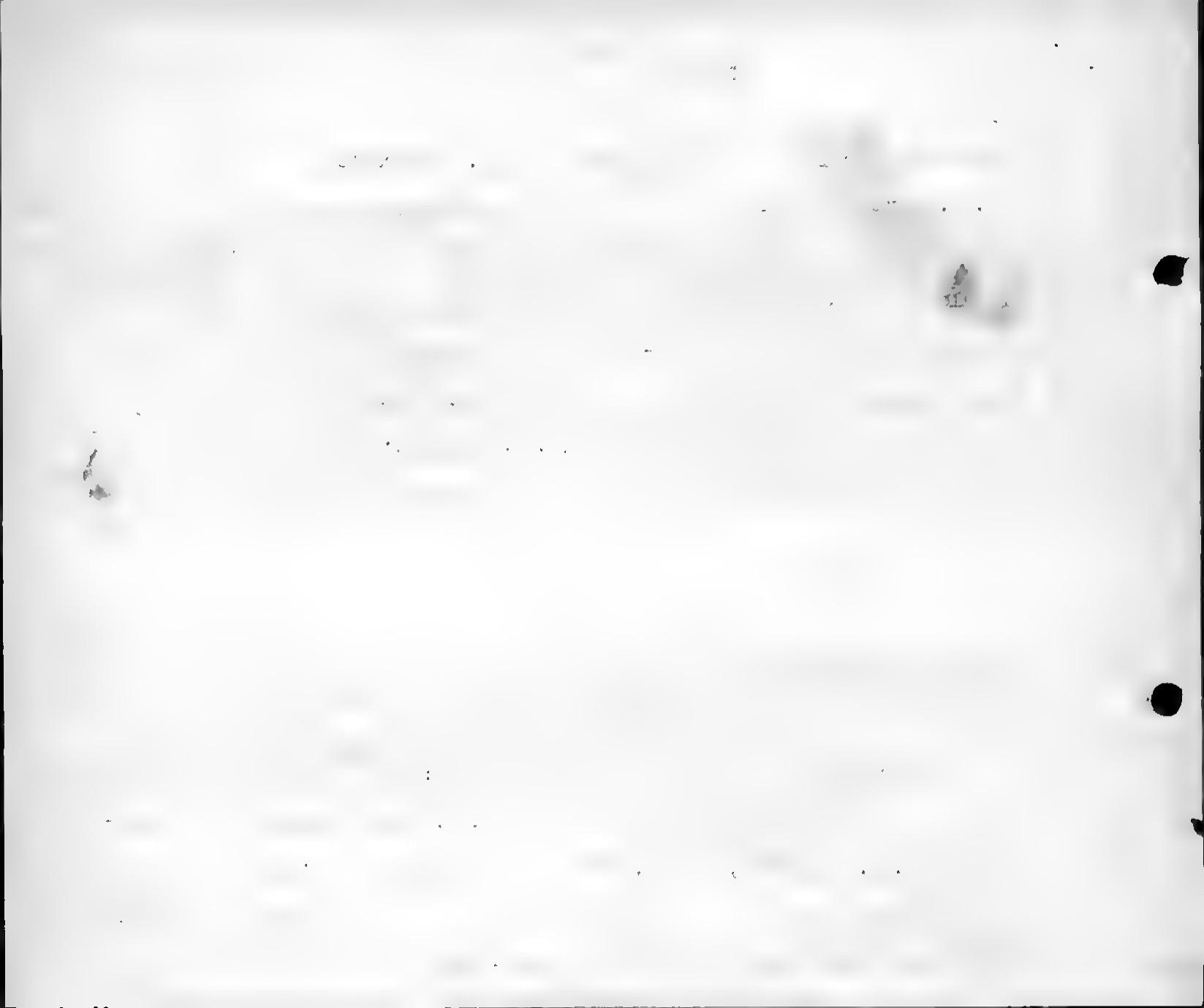
215

02198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|--------------------------------------|---|--|--|---------------------------------------|--|---------------------|----------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Florida | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 26 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Lauderdale | | d. STREET ADDRESS 1325 NE 16th Avenue | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Lela | Middle Macie | Last LINGLE | 4. DATE OF DEATH 2-3-13 | Month February | Day 4 | Year 1960 | | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 47 yrs. | 9. AGE (In years last birthday) 47 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Year 00 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | | 11. BIRTHPLACE (State or foreign country) Florida | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Otha BROWN | | | 14. MOTHER'S MAIDEN NAME Dollie Horn | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 266-14-9661 | | INFORMANT (H) F. J. Lingle, same as #2 above | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of The Thyroid DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 1/2 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) | | 20f. (City or town) Live Oak | | (County) Florida | (State) |
| 21. I certify that I attended the deceased from January 9, 1960 , to February 4, 1960 , that I last saw the deceased alive on February 4, 1960 , and that death occurred at 10:35A , from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2-4-60 | | | | | | | | | |
| ACTUAL SIGNATURE <i>R. G. Galbraith</i> M.D. | | | | | | | | | |
| PHYSICIAN'S NAME (Type) R. G. GALBRAITH, LT, MC, USN Bethesda 14, Maryland | | | | | | | | | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial-Shipments | | 22b. DATE THEREOF 2-5-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Baptist Cemetery | | 22d. LOCATION (City, town, or county) Live Oak | | (State) Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Chase Funeral Home</i> | | ADDRESS Chevy Chase Funeral Home, 5103 Wisc. Ave., NW, WD 6 | | 24a. REC'D BY REGISTRAR FEB 8 1960 | | 24b. REGISTRAR'S SIGNATURE <i>Orville J. Moore</i> | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 199 | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|
| 2122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) | | | | | | | | | | | |
| a. COUNTY | | | b. STATE | | | | | | | | | | | |
| Montgomery | | | Md | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | b. COUNTY | | | | | | | | | | | |
| Silver Spring | | | Montgomery | | | | | | | | | | | |
| c. LENGTH OF STAY IN lb | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | | | |
| 29 yrs | | | Silver Spring | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS | | | | | | | | | | | |
| 10000 Southerland Dr | | | 10000 Southerland Dr | | | | | | | | | | | |
| First Middle Last | | | 4. DATE OF DEATH | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | Feb 26 1960 | | | | | | | | | | | |
| Mary Ella Lyons | | | Month Day Year | | | | | | | | | | | |
| 5. SEX | | | 6. COLOR OR RACE | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 8. DATE OF BIRTH | | | | | |
| Female | | | White | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 4-10-1892 | | | | | |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| Housework | | | | | | | | | 67 yrs. | | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Henry Rogers | | | Mary E. Beach | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, where and date of service) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| No | | | None | | | Ira K. Barnes | | | 21-S.C. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | Address | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | | 706 Chestnut St Drexel Hill, Pa | | | | | | | | | | | |
| DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | Sudden | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | |
| 19 | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 22b. DATE THEREOF, 3/1/60 | | | Address (Street, city, town, or county) | | | | | | | | | | | |
| 22c. LOCATION (City, town, or county) | | | (State) | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR, ADDRESS | | | 24a. REC'D BY REGISTRAR | | | | | | | | | | | |
| W.H. Chambers Co., Inc., 3072 17th Street NW, Wash., DC | | | 24b. REG STAR'S SIGNATURE | | | | | | | | | | | |
| DATE MAR 1 '60 | | | Arthur S. Hanna | | | | | | | | | | | |



The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2148 CERTIFICATE OF DEATH

Reg. Dist. No.

02200

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|---------------------------------------|-----------------------------------|--|--|--|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | | | | | | | | | | | |
| Montgomery | | Maryland | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b 23 days | | | | | | | | | | | |
| Salisbury Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Springs | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 18003 Ark Crest Dr. | | | | | | | | | | | |
| Wash San & Hosp | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | | | | | | | | | | |
| Simon (NaN) | | Last | | | | | | | | | | | |
| 4. DATE OF DEATH | | Month | Day | | | | | | | | | | |
| 2 - 17 - 1960 | | Year | | | | | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years 1st birthday) yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. | | | | | | |
| Male | | White | | 4 - 22 - 76 | 85 | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| Furnace Set | | — | | Poland | | Amer. USA | | | | | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | Address | | | | | | | | | |
| Gershon Malinsky | | El Knaan | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | | INFORMANT | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| none | | 577-03-9863 | | pt Chastin Hosp | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal heart failure | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 19 | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from alive on | | | | | | | | 21/2, 1960 | | | | 21/7, 1960 | |
| and that death occurred at | | | | | | | | 6:10 p.m. | | | | that I last saw the deceased | |
| ACTUAL SIGNATURE | | | | | | | | ADDRESS (Street, City or Town, state) | | | | DATE SIGNED | |
| ARTHUR P. WILETS M.D. | | | | | | | | 909 Fernside Dr. S. Spg Md. 2/17/60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CEMATORI | | 22d. LOCATION (City, town, or county) | | (State) | | | | | |
| Burial | | 2/19/60 | | Beth Shalom Cemetery | | DC | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| Goldberg Funeral Home | | 4219 9th Street N.W. D.C. | | FEB 19 1960 | | Cathleen S. Knuehl | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02201

| | | | | | | |
|--|------------------------------|---|---|---|--------------------------------|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clifton</i> | | c. LENGTH OF STAY IN 1b <i>19 mo.</i> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Willie Seddon Marston</i> | | 4. DATE OF DEATH <i>Feb. 26 1960</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr. 13-1884</i> | | | |
| 9. AGE (In years lost birthday) <i>75 yrs.</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>Etna Mills - Va.</i> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Patrick Henry Eubank</i> | 14. MOTHER'S MAIDEN NAME <i>Sally Kerr</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>[Illegible]</i> | 17. INFORMANT <i>Hosp. Records</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Subarachnoid Hemm.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i> | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>X</i> | | DUE TO (b) <i>Sen. arteriosclerosis + Senile</i> | 10 yrs | | | |
| | | DUE TO (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>[Illegible]</i> | 20f. (City or town) <i>[Illegible]</i> | (County) <i>[Illegible]</i> | (State) <i>[Illegible]</i> |
| 21. I certify that I attended the deceased from <i>July 21- 1958</i> to <i>26 Feb 1960</i> that I last saw the deceased alive on <i>26 Feb 1960</i> , and that death occurred at <i>10:05 PM</i> , from the causes and on the date stated above. | | | | | | |
| MEDICAL CERTIFICATION SIGNATURE <i>John Bosley Ziegler M.D.</i> | | | | ADDRESS (Street, city or town, state) <i>Clifton, MD</i> | | |
| PHYSICIAN'S NAME (Type) <i>JOHN BOSLEY ZIEGLER</i> | | | | DATE SIGNED <i>26 Feb 60</i> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>2-29-60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Klassenaufer</i> | 22d. LOCATION (City, town, or county) <i>Woodstock</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>R.L. Billinger</i> | | ADDRESS <i>100 Woodstock Rd</i> | 24a. REC'D BY REGISTRAR <i>Arline S. House</i> | 24b. REGISTRAR'S SIGNATURE <i>Arline S. House</i> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3173 CERTIFICATE OF DEATH

02202

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | c. LENGTH OF STAY IN 1b 57 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | d. STREET ADDRESS 5115 Wessling Lane |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Ida | Middle F. | Last McCarthy |
| 4. DATE OF DEATH | Month Feb | Day 2 | Year 1960 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 7, 1884 |
| 9. AGE (In years last birthday) 75 yrs | 10. IF UNDER 1 YEAR Months 4 | 11. IF UNDER 24 HRS Days 25 | Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maine | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME William Sweeney | 14. MOTHER'S MAIDEN NAME Sarah Logan | Address | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? No | 16. SOCIAL SECURITY NO. - - - - - | 17. INFORMANT William J. McCarthy, Jr. - Item #2 - Son | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 1702 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO Metastatic - Carcinomatosis (Breast) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 30 hrs. two years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1955, to February 21960, that I last saw the deceased alive on February 1, 1960, and that death occurred at 5:40 P.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Frank Jaggers Jr. M.D.</i> | ADDRESS (Street, city or town, state) 5707 WISCONSIN AVE | | DATE SIGNED 2/2/60 |
| PHYSICIAN'S NAME (Type) Frank Jaggers Jr. M.D. | CHEVY CHASE 15, Md. | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Bur-Trans. 2-4-60 | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Pleasant Cemetery | 22d. LOCATION (City, town, or county) Bangor, Maine (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | ADDRESS | 24a. REC'D BY REGISTRAR FEB 8 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exercised within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~copied~~ filled in by the funeral director, page 3 should be detached for use as the burial-transmit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

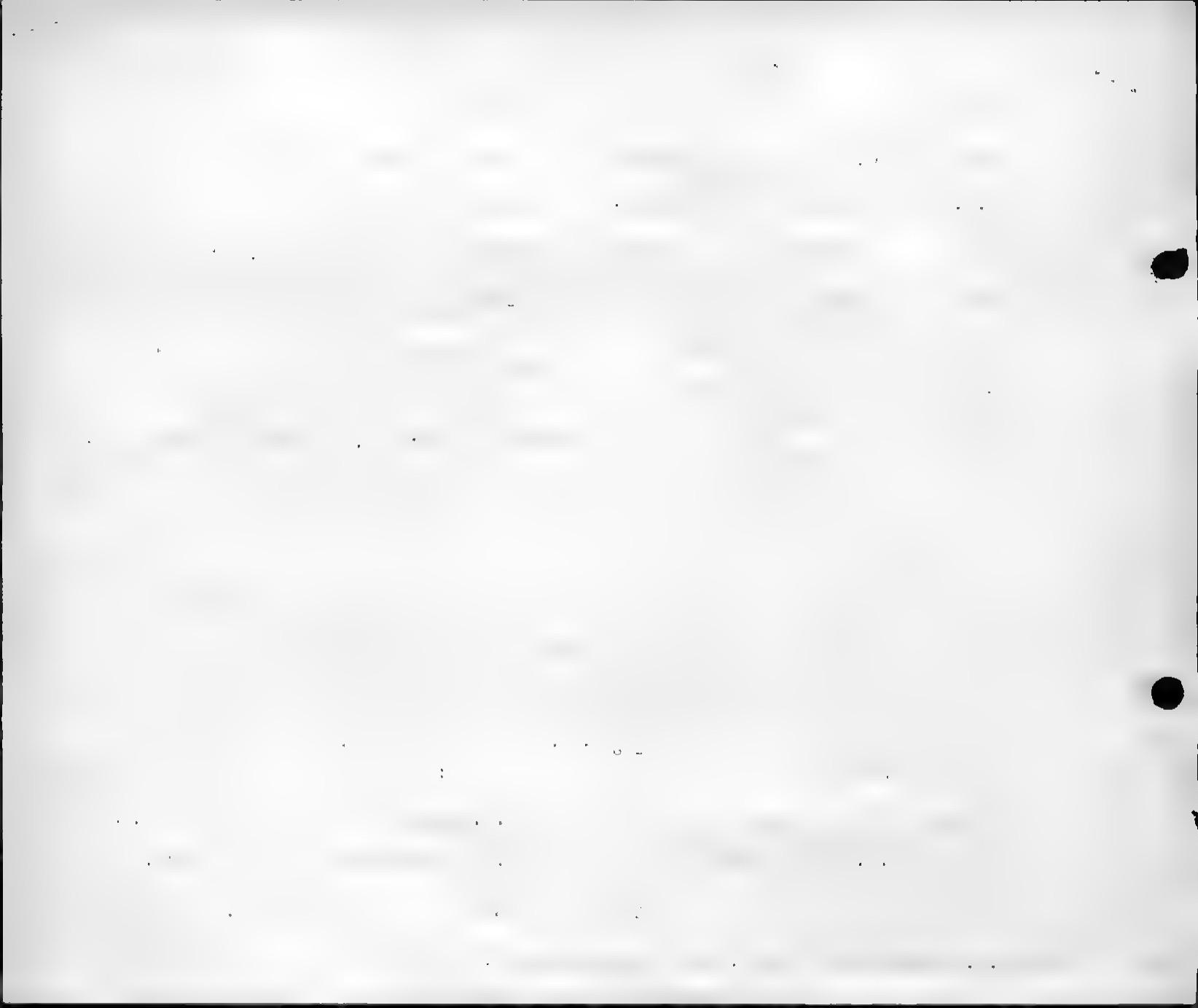
02203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | c. LENGTH OF STAY IN lb 34 days | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | |
| 3. NAME OF DECEASED (Type or print) Helen Adrey MC CULLAH | | | 4. DATE OF DEATH Month Day Year February 25 1960 | | |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 10-23-07 | 9. AGE (In years last birthday) 52 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Fred GANT | | | 14. MOTHER'S MAIDEN NAME Evelyn BARBER | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (Husband) Harry F. MC CULLAH | INFORMANT Same as #2 | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>19-1-X</i> DUE TO <i>Carcinoma, breast with metastases</i> | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 5 mos. | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) U.S. Naval Hospital, Bethesda Md. | (County) (State) |
| 21. I certify that I attended the deceased from 22 January 1960 to 25 February 1960 , that I last saw the deceased alive on 25 February 1960 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. | | | | | |
| DATE SIGNED 2-26-60 | | | | | |
| ACTUAL SIGNATURE <i>E.J. Rupnik</i> | | | | | |
| PHYSICIAN'S NAME (Type) E.J. RUPNIK LCDR MC USN | | | | | |
| U.S. Naval Hospital, Bethesda Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-1-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington Va. | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. HINES</i> | | | ADDRESS 2901 14th St. N.W. Washington D.C. | 24a. REC'D BY REGISTRAR FEB 29 '60 | 24b. REGISTRAR'S SIGNATURE <i>C. L. Kline</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 259 S-31-60 AMS

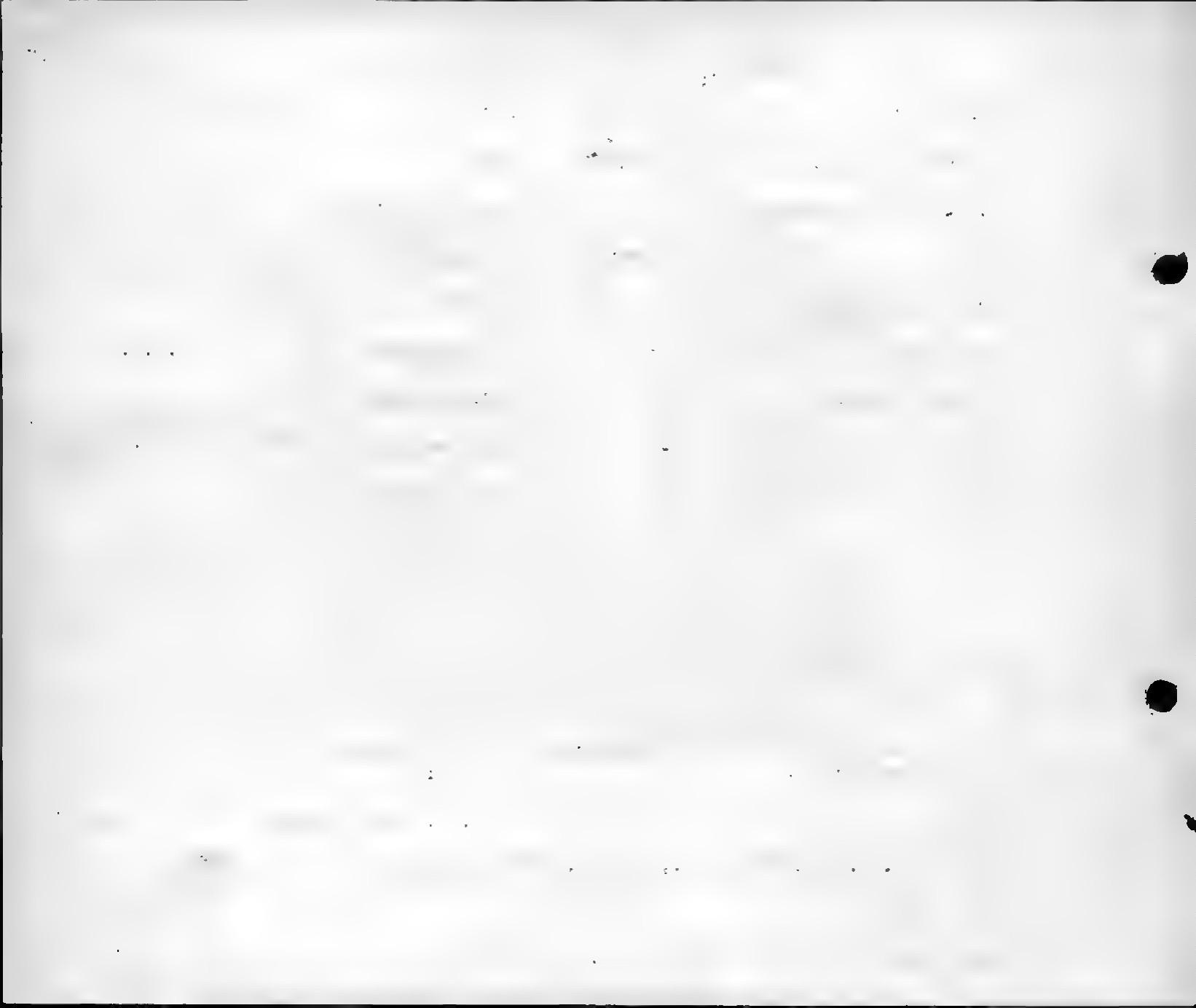
02204

2243

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | | | |
|---|--|---|---|--|--|---|---|---------------------|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia | | b. COUNTY Arlington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | d. STREET ADDRESS 83 X 3916 4th Street N. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Estella | | First Estella | Middle Mary | Last MC DERMOTT | 4. DATE OF DEATH February 15 1960 | Month February | Day 15 | Year 1960 | |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-20-76 | | 9. AGE (In years last birthday) 83 yrs | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - - - | | 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William BUSBY | | | | 14. MOTHER'S MAIDEN NAME Bridget WELSH | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (D) Katherine Herrold, Trotter Rd. Rt. 29 | | Address: Clarksville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diverticulitis and diverticulitis with abscess</i> DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> (b) <i>Perforation of right-sided colon/abscess</i> DUE TO <i>and perforation of descending colon.</i> (c) <i>Paroxysms</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH 575.1 | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | |
| 21. I certify that I attended the deceased from February 13, 1960 , to February 15, 1960 , that I last saw the deceased alive on February 15, 1960 , and that death occurred at 8:57 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. G. Galbraith</i> PHYSICIAN'S NAME (Type) R. G. GALBRAITH, JR., LT, MC, USN | | ADDRESS (Street, city or town, state) U. S. Naval Hospital | | DATE SIGNED 2-15-60 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | | 22b. DATE THEREOF 2-16-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross | | 22d. LOCATION (City, town or county) Fargo | | (State) No. Dakota | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ives Funeral Home, 2847 Wilson Blvd. Arlington,</i> | | ADDRESS Va. | | 24a. REC'D BY REGISTRAR FEB 16 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Finch</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 Film G-278 3-8-60 et

CERTIFICATE OF DEATH

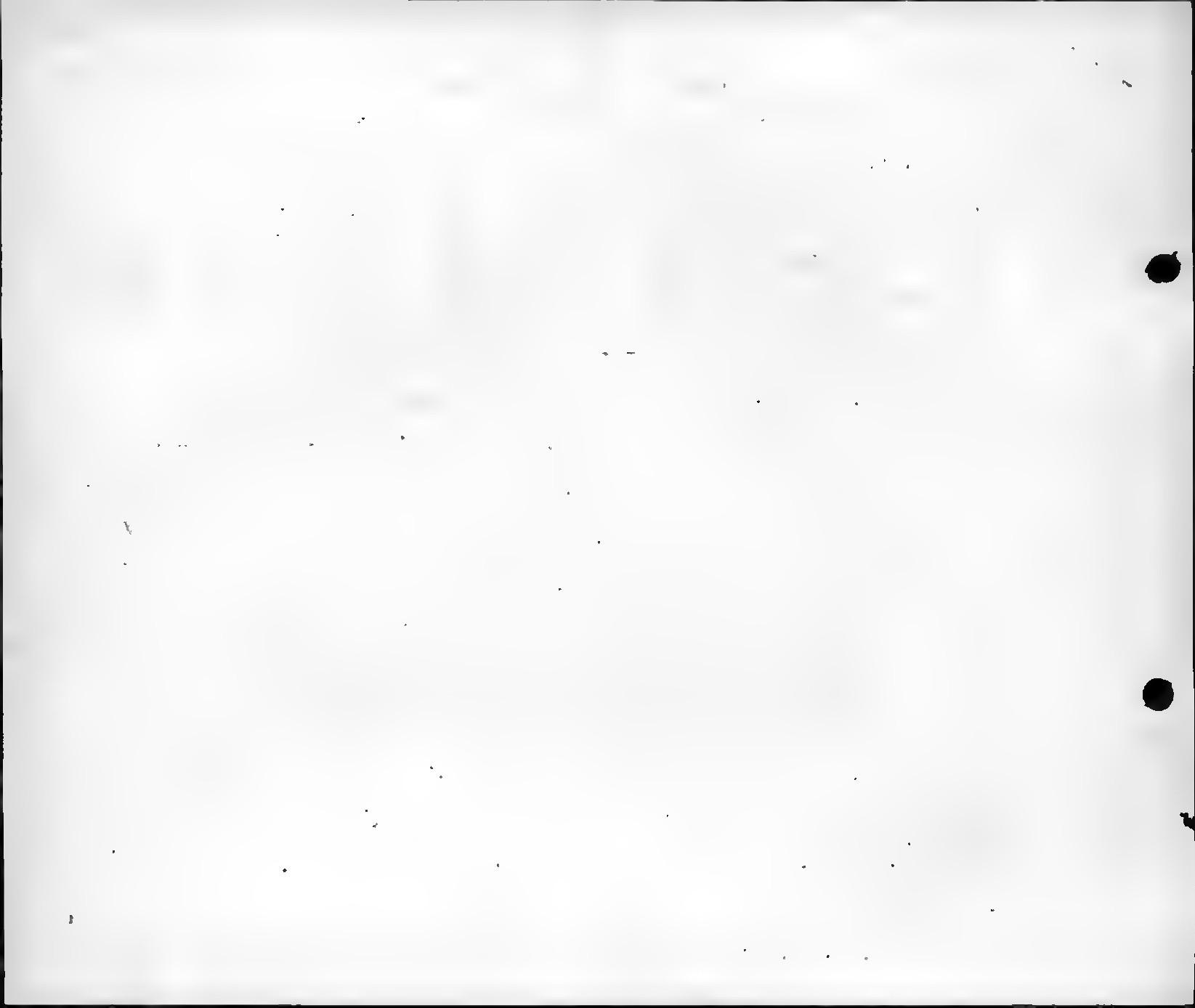
02205

Reg. Dist. No.

| | | | | | |
|--|--|---|--------|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2245 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE | |
| Montgomery MARYLAND | | | | Maryland Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Nursing Home | | | | d. STREET ADDRESS 1609 Sanford Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | Last | 4. DATE OF DEATH Month Day Year |
| Margaret Isabel | | | | McElroy | February 22 1960 |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/5/1873 |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 9. AGE (In years last birthday) 86 yrs. 12. CITIZEN OF WHAT COUNTRY? US |
| 13. FATHER'S NAME Ben F. Sheffer, Benjamin F. | | 14. MOTHER'S MAIDEN NAME Matty Elkin, Margaret | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO Unknown | | 17. INFORMANT Miss Olive McElroy—daughter-same 2d | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) S 44V DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO Arteriosclerosis | |
| 19. MEDICAL CERTIFICATION | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Right hemiplegia | | 21. I certify that I attended the deceased from <u>March 23 1959</u> to <u>Feb 22 1960</u> , that I last saw the deceased alive on <u>Feb 22 1960</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John J. Fawcett</u> M.D. <u>Dawsonville, P.O. Bayard, Md.</u> PHYSICIAN'S NAME (Type) <u>John J. Fawcett</u> Dawsonville, Md. DATE SIGNED <u>Feb 23 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 2/24/60 | | 22b. DATE THEREOF 2/24/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Homewood Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 22d. LOCATION (City, town, or county) Pittsburgh, Pennsylvania | |
| | | | | 24a. REC'D. BY REGISTRAR FEB 26 '60 | 24b. REGISTRAR'S SIGNATURE <u>James L. Evans</u> |
| | | | | DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

102206

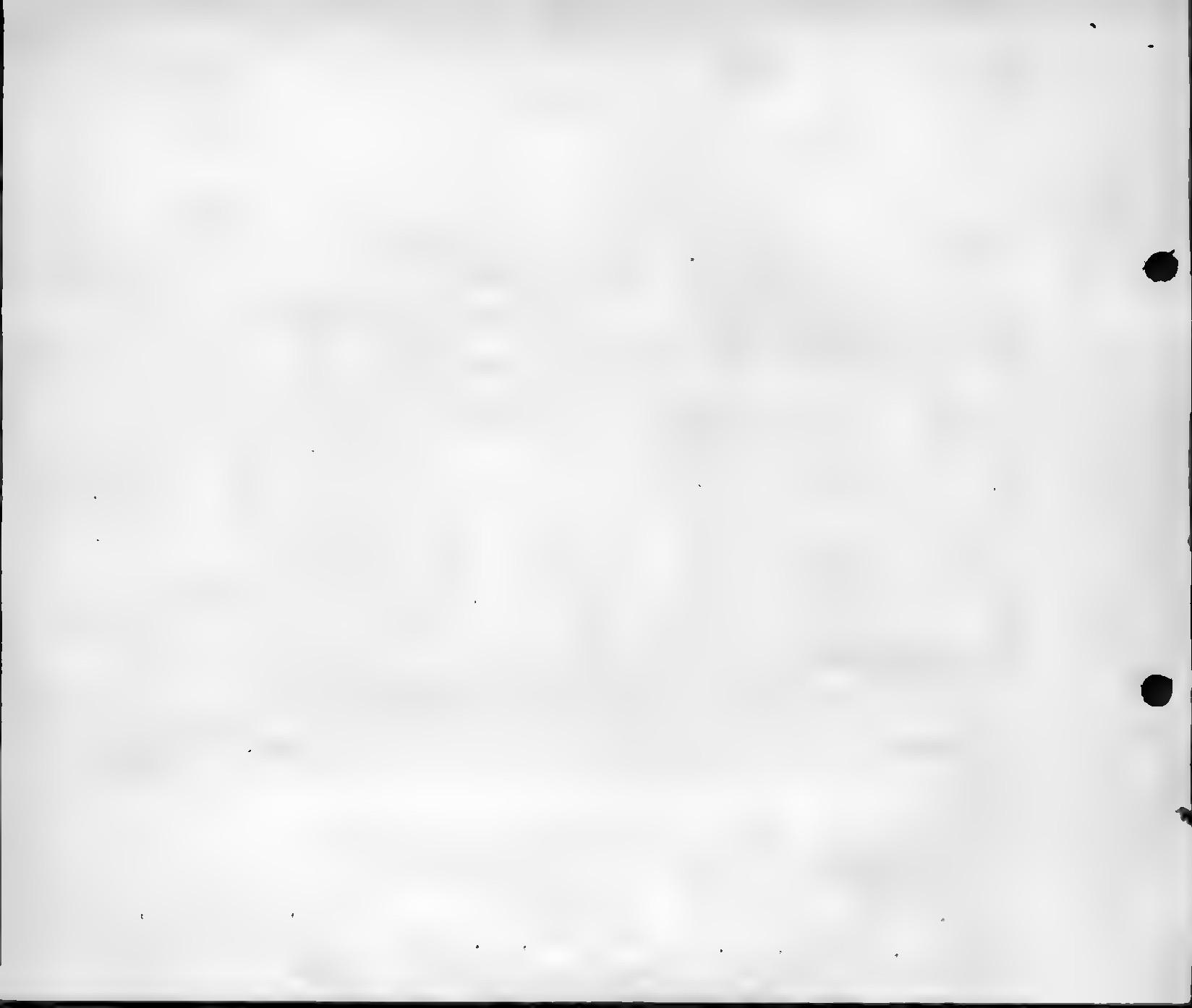
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. Certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

091

| | | | | | | | | |
|--|--|---|---|---|------------------------|---|---|-----------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2245 Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Md b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb Ednor 9 mo | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | Belmont Nursing Home | | Hyattsville 7400 25th Ave | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First Mary | Middle A. | Lost | 4. DATE OF DEATH | Month Feb | Day 9 | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH | 8. 1-26-1880 | | IF UNDER 1 YEAR Months Days Hours Min | | |
| Female | | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 80 yrs. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most recent year, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Nursing Home | | OWN HOME | | Ill | | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, rank, or unknown) | | 16. SOCIAL SECURITY NO. | | |
| Joseph Moran | | Mary Murphy | | No | | 17. INFORMANT | | |
| | | Nursing Home Record - Item 1 | | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Sudden DUE TO (c) Generalized arterio sclerosis years | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I (o) | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCHELT | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED 2-9-60 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 2/9/60 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) EVANSTON, COOK COUNTY, ILLINOIS | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. | | ADDRESS | | SILVER SPRING, MD. | | (State) | | |
| | | | | | | 24a. REC'D BY REGISTRAR DATE FEB 11 '60 | 24b. REGISTRAR'S SIGNATURE Cuthbert S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,9 File #257 2-29-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02207

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>Buchanan</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Maryland</i> | | c. LENGTH OF STAY IN b. <i>4 years</i> | |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Maryland</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Santurin</i> | | d. STREET ADDRESS <i>9200 Wisconsin Ave</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Helen</i> | Middle <i>V</i> | 4. DATE OF DEATH <i>McLeod 12/18/1960</i> |
| S. SEX <i>Male</i> | 6 COLOR OR RACE <i>White</i> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12/18/1867</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Government</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i> | 10c. BIRTHPLACE (State or foreign country) <i>Buchanan, Virginia USA</i> | 12 CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>James S Martin</i> | 14. MOTHER'S MAIDEN NAME <i>Finney</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>—</i> | INFORMANT <i>Lee Martin - 5521 Coleridge Rd NW</i> | Address <i>Wash. D.C.</i> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | |
| <i>332 X</i> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| DUE TO (b) | | | |
| <i>Viral Pneumonia</i> | | | |
| DUE TO (c) | | | |
| <i>Cerebral Thrombosis with right sided facial paralysis</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| Particulars <i>Senility</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White at work</i> | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | 20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | |
| 21. I certify that I attended the deceased from <i>July 12, 1956</i> to <i>Feb 23, 1960</i> that I last saw the deceased alive on <i>Feb 22, 1960</i> and that death occurred on <i>Feb 23, 1960</i> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <i>Philip E. Jones</i> | M.D. | ADDRESS (Street, city or town, state) <i>98 Ellsworth Dr</i> | DATE SIGNED <i>2/23/60</i> |
| PHYSICIAN'S NAME (Type) | <i>Philip E. Jones</i> | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <i>3/25/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON Nat Cem. Arlington VA</i> | 22d. LOCATION (City, town or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Lees - Wash. D.C.</i> | ADDRESS | 24a. REC'D BY REGISTRAR <i>DATE 25 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> |



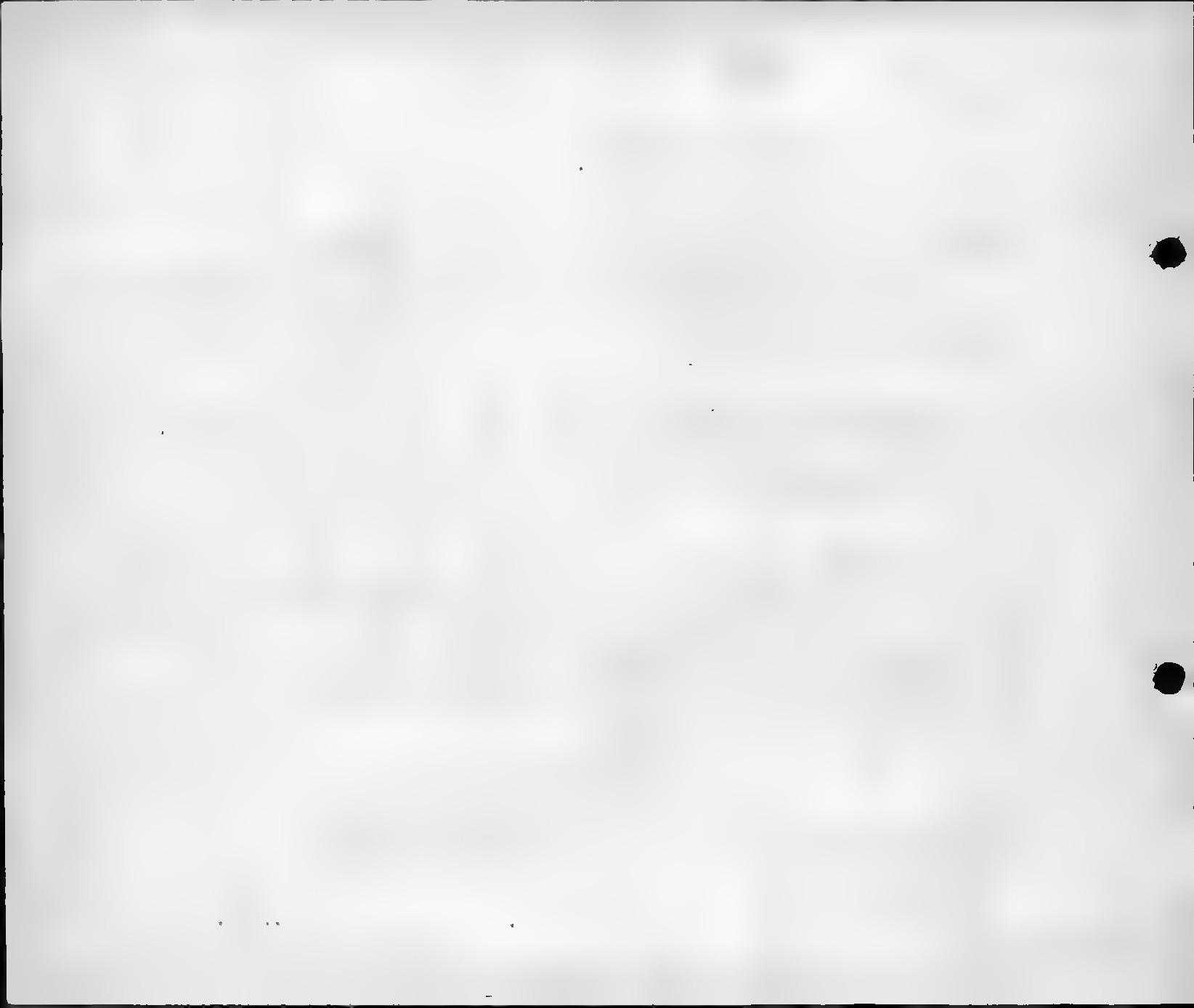
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02208

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial or removal.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| Montgomery | | b. STATE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| Rockville Park | | 16 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Washington Sanitarium & Hospital | | Silver Spring | |
| f. STREET ADDRESS | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 8600 Glenville Rd. | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| Charles | | Jay | Meister |
| Last | | 4. DATE OF DEATH | Month Day Year |
| 1772 | | 2 | - 23 1960 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> 8. DATE OF BIRTH |
| Male | | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2-3-09 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Waiter | | self | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Baltimore Md. | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| (Unknown) ? | | Sarah ? (unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT | |
| (If yes, give war or dates of service) | | 215-10-7742 Mrs. Alice Eliz. Meister - 11 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | 19. INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | Cause of death | |
| 420.1 | | DUE TO | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | |
| DUE TO | | (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | DATE SIGNED | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| FRANK J. Bloschitz | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| Burial | | 2/26/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 22d. LOCATION (City, town, or county) (State) | |
| Loudon Park Cem. | | Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | |
| John J. Siekner & Sons - Balt. 17 | | Date 2/25/60 | |
| | | 24b. REGISTRAR'S SIGNATURE | |
| | | John J. Siekner | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Form No. 3-7-H-6 et
CERTIFICATE OF DEATH

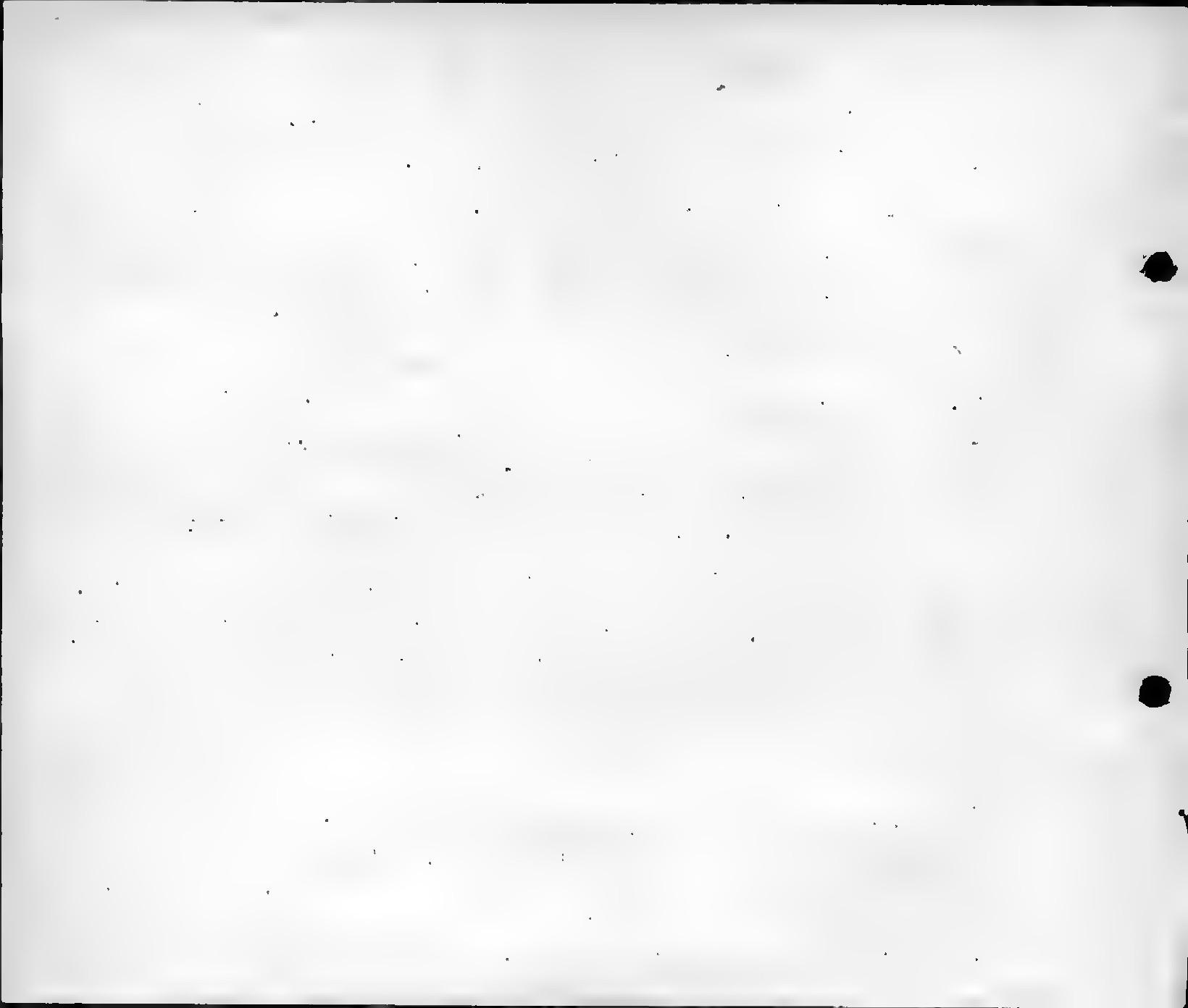
02209

Reg. Dist. No.

2247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---------------------------------------|--|----------------------------------|--|---|--|--|--|-------------------|--|------------------|--|----------------|--|--------|--|------------------|--|--|--|------------------|--|---------------------------------------|--|-----------------|--|-----------------|--|----|--|----|--|----|--|----|--|----|--|----|--|--|--|--|--|--|--|
| 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | | 11 | | 12 | | 13 | | 14 | | 15 | | 16 | | 17 | | 18 | | 19 | | 20 | | 21 | | 22 | | 23 | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | a. STATE | | Washington D.C. | | b. COUNTY | | 3. NAME OF DECEASED (Type or print) | | First MIDDLE LAST | | 4. DATE OF DEATH | | Month Day Year | | 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) / yrs | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | 5623 FIRST ST. N.W. | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| - BETHESDA MD | | 3 Days | | WASHINGTON, D.C. 20501 | | 5623 FIRST ST. N.W. | | 17 19 60 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Suburban Hosp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Housewife | | Own Home | | Georgia | | | | | | 21. S. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME | | ALEX JAMES | | 14. MOTHER'S MAIDEN NAME | | FANNIE BUCK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | | INFORMANT | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | 1475 MARGARET CHEASPEAKE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Pulmonary atelectasis | | | | | | 1 hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 570.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO (b) | | Aspiration of intestinal contents | | | | | | 1 hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO (c) | | Hemorrhage venous thrombosis-infarct | | | | | | 4 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, Part II, or item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from _____, 1958, to _____, 1960, that I last saw the deceased alive on _____, 1960, and that death occurred at _____, M, from the causes and on the date stated above | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | P. L. TABB, M.D. 13000 9A AUG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) | | S. L. TABB, M.D. 511 S. St. MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) | | (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Transportation | | 2/18/60 | | Augusta | | Georgia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F. Gasch's Sons | | Hyattsville, Maryland. | | DATE FEB 19 '60 | | Arthur S. Krause | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



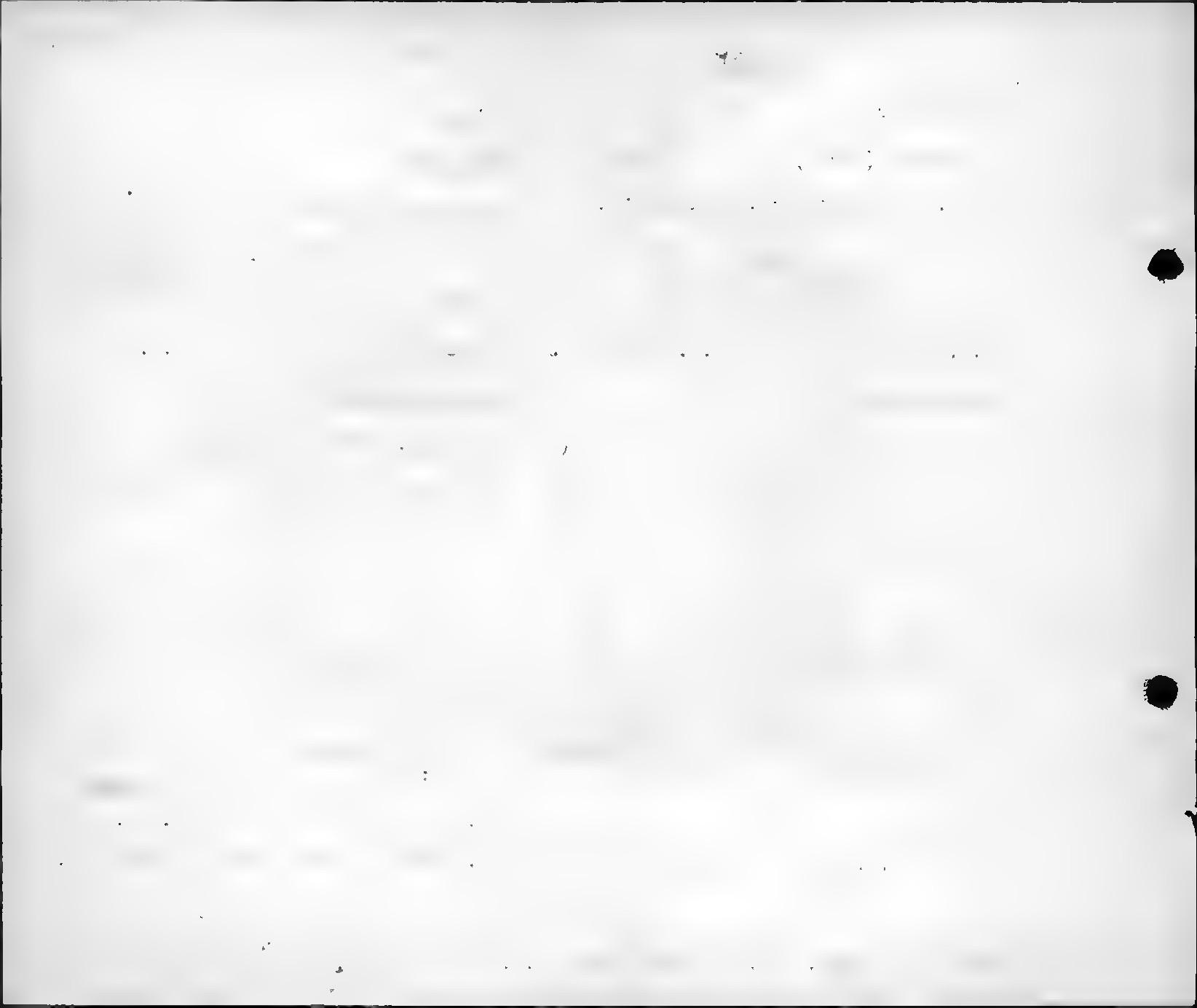
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

(12210)

| | | | | | | | |
|--|--|--|--|--|---|---|---|
| <p>1. PLACE OF DEATH a. COUNTY Montgomery 224S</p> <p>MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural)</p> <p>c. LENGTH OF STAY IN 1b 12 days</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) <small>OR LAST TUTOR</small> U.S. Naval Hospital, Bethesda Md.</p> | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY</p> <p>e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant</p> <p>d. STREET ADDRESS 6105 Clearfield Drive</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | |
| <p>3. NAME OF DECEASED <small>(Type or print)</small> William Edgvert METTS</p> | | <p>First William</p> | <p>Middle Edgvert</p> | <p>Last METTS</p> | <p>4. DATE OF DEATH Month February Day 29 Year 19 60</p> | | |
| <p>5. SEX Male</p> | <p>6. COLOR OR RACE White</p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 2-27-07</p> | | <p>9. AGE (In years last birthday) 53 yrs</p> | <p>IF UNDER 1 YEAR Months 0 Days 0</p> | <p>IF UNDER 24 HRS Hours 0 Min. 0</p> |
| <p>10a. JSLA OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy</p> | | | <p>10b. KIND OF BUSINESS OR INDUSTRY U.S. Government</p> | | <p>11. BIRTHPLACE (State or foreign country) Georgia</p> | | |
| <p>13. FATHER'S NAME Horace METTS</p> | | | | <p>14. MOTHER'S MAIDEN NAME Hattie DONALDSON</p> | | | |
| <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small> Yes</p> | | | <p>16. SOCIAL SECURITY NO. <small>If yes, give war or dates of service</small> WW II</p> | | <p>INFORMANT (Wife) Marie U. METTS Same as #2</p> | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I DEATH WAS CAUSED BY. <small>IMMEDIATE CAUSE (a)</small> 33dx DUE TO Basilar Artery Thrombosis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO } (c)</p> | | | | <p>INTERVAL BETWEEN ONSET AND DEATH 12 days</p> | | | |
| <p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> | | | | | | | <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19</p> | | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) <small>(County)</small> <small>(State)</small></p> | |
| <p>21. I certify that I attended the deceased from 17 February, 19 60, to 29 February, 19 60, that I last saw the deceased alive on 29 February, 19 60, and that death occurred at 10:05AM, from the causes and on the date stated above.</p> | | | | | | | |
| <p>ACTUAL SIGNATURE <i>James M. Brown</i></p> | | | | <p>ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. 3-120</p> | | | |
| <p>PHYSICIAN'S NAME (Type) J. M. BROWN LT MC USN</p> | | | | <p>DATE SIGNED</p> | | | |
| <p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p> | | <p>22b. DATE THEREOF 3-3-60</p> | | <p>22c. NAME OF CEMETERY OR CREMATORIUM Arlington National</p> | | <p>22d. LOCATION (City, town, or county) Arlington Va.</p> | |
| <p>23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Service 300-4458</i></p> | | | | <p>ADDRESS Lee 4th and Mass. Ave. N.W. Washington D.C.</p> | | <p>24a. REC'D BY REGISTRAR DATE MAR 2 '60</p> | <p>24b. REGISTRAR'S SIGNATURE <i>Albert L. Flora</i></p> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1b & c from 3-58 3-160 iwk

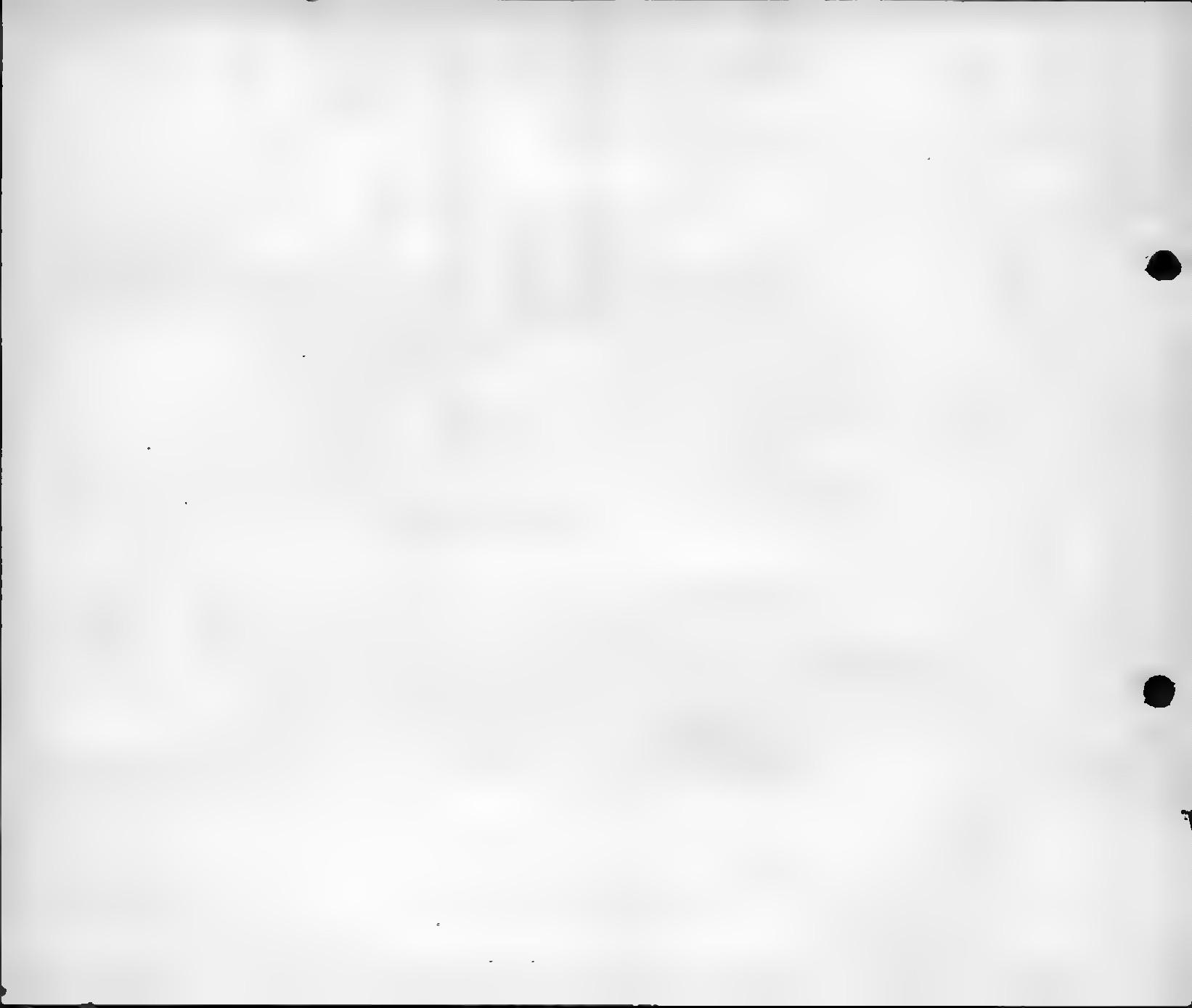
2249

CERTIFICATE OF DEATH

Reg. Dist. No.

02211

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md. | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION h r residence-13300 Georgia Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Maud | Middle E | Last Meyer |
| 4. DATE OF DEATH | Month February | Day 28 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 8, 1893 |
| 9. AGE (In years last birthday) 66 yr. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME John W. Berkeley | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Allen | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Dorothea E. Marek Address 13300 Ga. Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, LEFT lung. - DUE TO 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombus left. Right. ATRIUM DUE TO (c) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 2/27, 1960, to 2/28, 1960, that I last saw the deceased alive on 2/27, 1960, and that death occurred at 2:00 PM, from the causes and on the date stated above ACTUAL SIGNATURE A.W. Smith PHYSICIAN'S NAME (Type) A.W. SMITH | ADDRESS (Street, city or town, state) M.D. 13018 Georgia Ave Silver Spring | | DATE SIGNED 2/28/60 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Mar 2, 1960 Congressional Cem. | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 4812 Ga. Ave N. W. | 22d. LOCATION (City, town, or county) (State) Washington D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home | ADDRESS 4812 Ga. Ave N. W. | 24a. REC'D BY REGISTRAR DATE MAR 7 '60 | 24b. REGISTRAR'S SIGNATURE Arline S. Kaud |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2250 CERTIFICATE OF DEATH

Reg. Dist. No.

02212

| | | | | | | | |
|--|---------------------------------|--|---|---|--|---|-------------------|
| PLACE OF DEATH a. COUNTY Montgomery | | MATERIAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia | | b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 33 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 2377 North Quincy Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Anna | Middle Jane | Last Montgomery | 4. DATE OF DEATH February | Month 9 | Day 19 | Year 60 |
| 5. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 28, 1938 | | 9. AGE (In years last birthday) 21 yrs. | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stephen Miles Montgomery | | | | 14. MOTHER'S MAIDEN NAME Annie G. Roberts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 weeks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Acute lymphocytic leukemia 2 months DUE TO (c) | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 7, 1960 , to February 9, 1960 that I last saw the deceased alive on February 9, 1960 , and that death occurred at 6:45 PM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED Lawrence A. Gaydos 2/10/60 | | | | | | | |
| ACTUAL SIGNATURE Lawrence A. Gaydos M.D. The Clinical Center PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D. National Institutes of Health Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/10/1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM Columbia Gardens | | 22d. LOCATION (City, town, or county) Arlington, Virginia (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Morris | | ADDRESS Arlington, 3, Va. Arlington Funeral Home 3901 No. Fairfax Drive | | 24a. REC'D BY REGISTRAR FEB 15 '60 | | 24b. REGISTRAR'S SIGNATURE Carla S. Morris | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

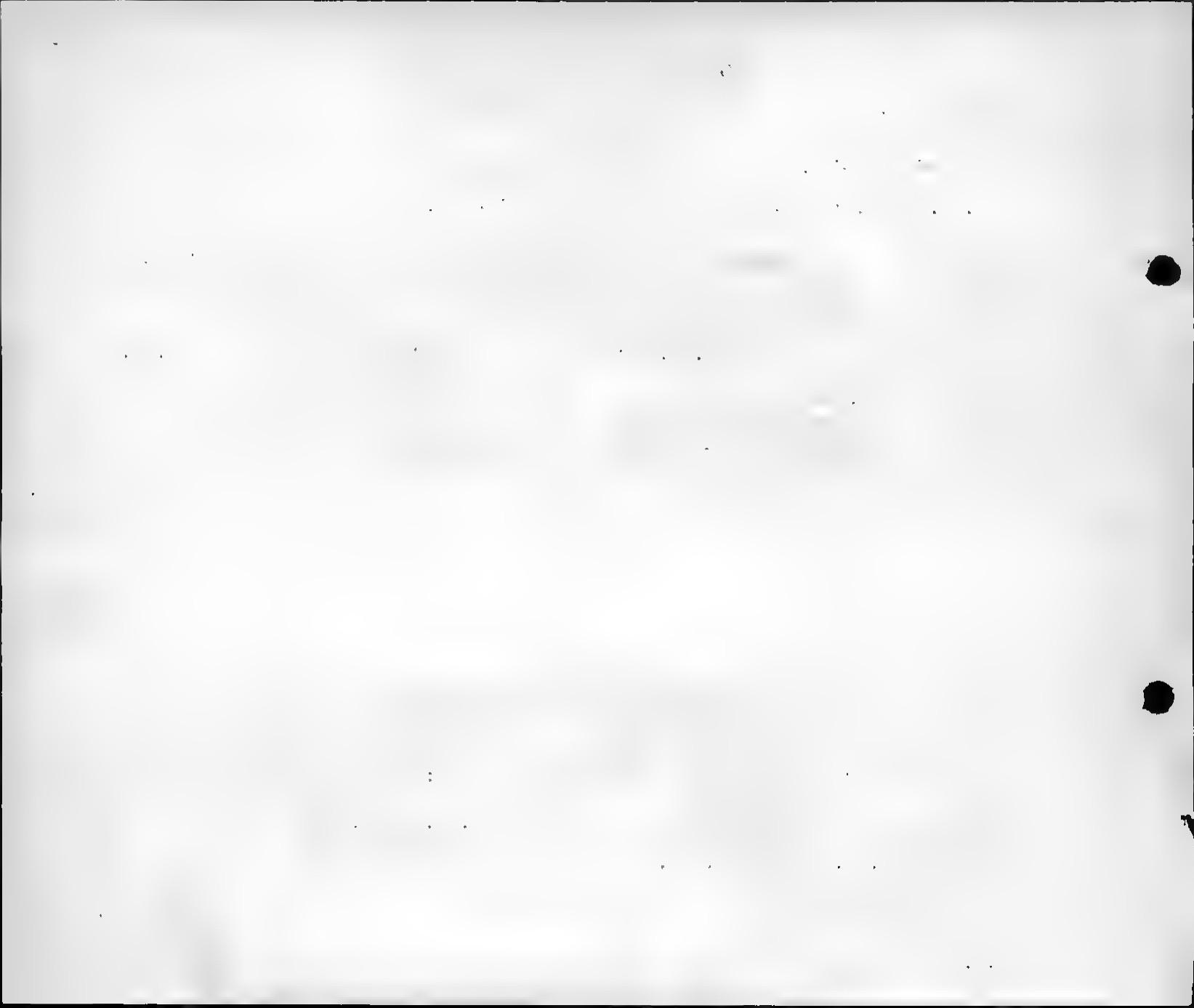
2251 CERTIFICATE OF DEATH

02213

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|-------------------------------------|---|--|--|---|---|--------------------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Tennessee | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 316 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chattanooga | | d. STREET ADDRESS 3714 St. Elmo Avenue | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Eugene | | First | Middle | Last | 4. DATE OF DEATH February 13 | Month | Day | Year |
| S. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-6-39 | 9. AGE (In years last birthday) 20 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. LAST OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | | 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME William MONTGOMERY | | 14. MOTHER'S MAIDEN NAME Iola BROOKS | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 1957 to DOD 414-46-4698 | | INFORMANT Hospital Records | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196.4 DUE TO Pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Metastatic disease DUE TO (c) Osteosarcoma of left humerus INTERVAL BETWEEN ONSET AND DEATH 7 months 1 year | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from April 3, 1959 , to February 13, 1960 , that I last saw the deceased alive on February 13, 1960 , and that death occurred at 8:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | | |
| ACTUAL SIGNATURE <i>N. T. DeBevoise</i> | M.D. | | U. S. Naval Hospital | | 2-13-60 | | | |
| PHYSICIAN'S NAME (Type) N. T. DEBEVOISE, LT, MC, USN | Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial-Shipment | 22b. DATE THEREOF 2-16-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Chattanooga National | | | 22d. LOCATION (City, town, or county) Chattanooga | | | (State) Tenn. |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>George Davis</i> | | ADDRESS W.W.Chambers Co., 1400 Chapin St, NW, Wash DC | | 24a. REC'D. BY REGISTRAR FEB 16 60 | | 24b. REGISTRAR'S SIGNATURE <i>Albert J. Perna</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02214

| | | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--------------------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2252 | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 7 HR. 25 MIN | d. STATE MARYLAND | | e. STATE MARYLAND | | | |
| | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG | d. STREET ADDRESS Rural | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, Inc. RT. #3 SHADY GROVE ROAD | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JAMES | | First JAMES | Middle FRANKLIN | Last MOORE | 4. DATE OF DEATH FEBRUARY 20 1960 | Month FEBRUARY | Day 20 | Year 1960 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/30/97 | | 9. AGE in years lost 1st birthday 62 yrs. | IF UNDER 1 YEAR Months 10 | IF UNDER 24 HRS Days 20 | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATING ENGINEER | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt., ret. | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME JAMES MOORE | | | | 14. MOTHER'S MAIDEN NAME TINA --- Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No WWI 1917-1918 | | 16. SOCIAL SECURITY NO. Yes-Unknown | | 17. INFORMANT HOSPITAL RECORDS | | Address OLNEY, MD. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 422.1 | | DUE TO Urinary | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | DUE TO Nephritis. | | | | | | |
| DUE TO Chronic myocarditis, Emphysema. | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) GAITHERSBURG | (County) MONTGOMERY | (State) MARYLAND |
| 21. I certify that (I) (this hospital) attended the deceased from 1948 , to 2-19-1960 , that (I) (we) last saw the deceased alive on Feb 19 1960 , and that death occurred at 2:50 PM . From the causes and on the date stated above | | | | | | | | |
| 22a. SIGNATURE L. L. LEAL, M. D. | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22b. DATE SIGNED 2/19/60 | | |
| 22c. PHYSICIAN'S NAME (Type) L. L. LEAL, M. D. | | 22d. ADDRESS GAITHERSBURG, MARYLAND | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/23/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Forest Oak Cemetery | | 23d. LOCATION (City, town, or county) Gaithersburg, Md. | | (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR DATE FEB 24 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

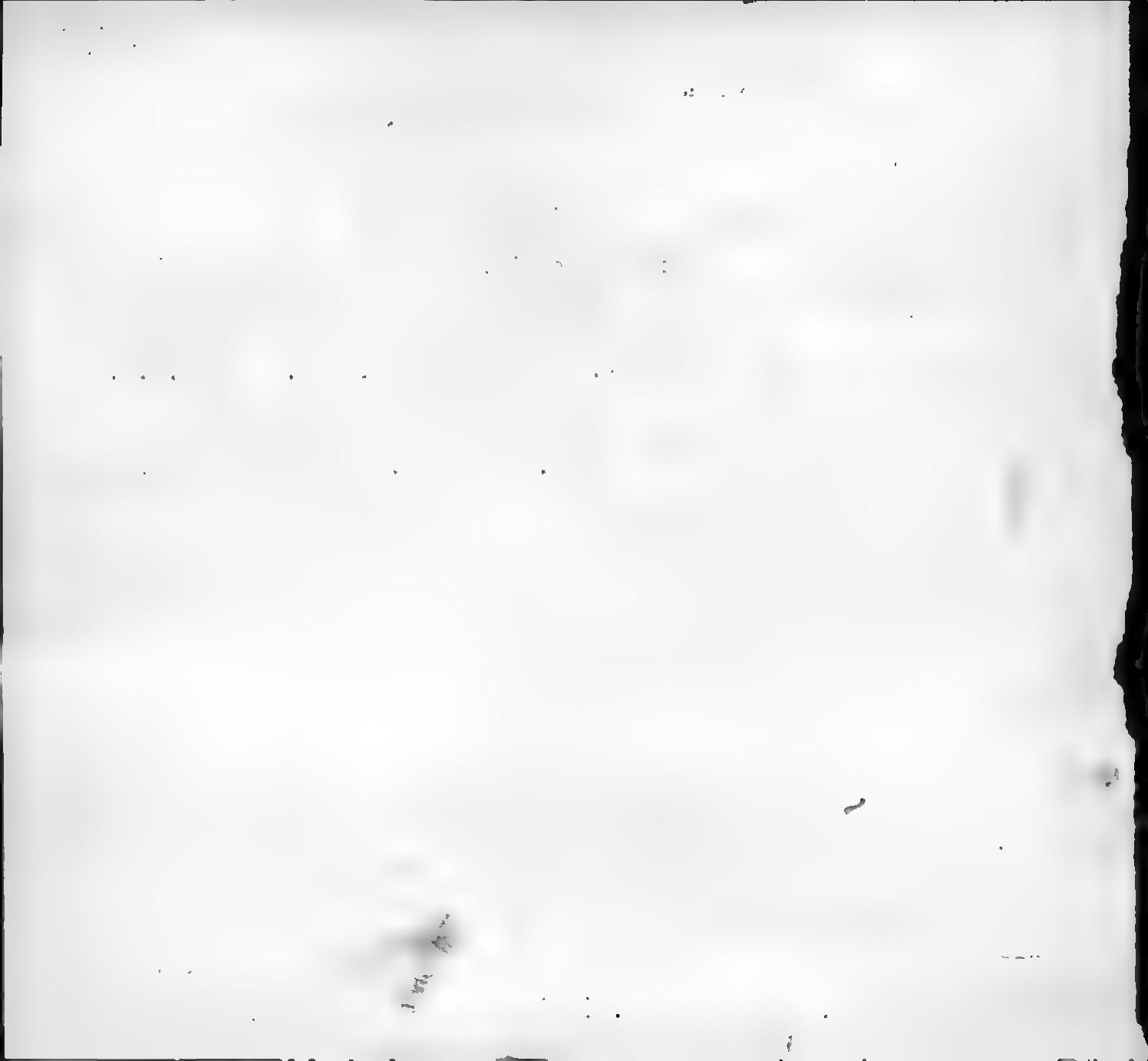
2123

CERTIFICATE OF DEATH

Reg. Dist. No.

02215

| | | | |
|---|------------------------------------|---|------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| Montgomery MARYLAND | | Md. Man ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Silver Spring | | 56 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS | | |
| 10219 Southmoor Drive | 10219 Southmoor Drive | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last |
| | Paul | Henry | Moreland |
| 4. DATE OF DEATH | Month | Day | Year |
| | Feb | 19 | 1960 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH |
| Male | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Dec 15, 1888 |
| 8. AGE (In years last birthday) | 9. IF UNDER 1 YEAR IF UNDER 24 HRS | | |
| 71 yrs | Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Retired, Chief Finance | | U.S. Govt. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Washington, D.C. | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| William S. Moreland | | Susanna Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) | | 16. SOCIAL SECURITY NO. | |
| | | INFORMANT | |
| | | Mrs. Miriam M. Chester | |
| 17a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | Address | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 48IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AORTIC STENOSIS | | INTERVAL BETWEEN ONSET AND DEATH 4 DAYS | |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 18c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. PLACE OF INJURY (Home, farm factory, street office bldg., etc.) 20e. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 5, 1960, to FEB 19, 1960, that I last saw the deceased alive on FEB 19, 1960, and that death occurred at 7:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: Harry Zehner M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) HARRY ZEHNER DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> | | 22b. DATE THEREOF 2/22/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) Washington, D.C. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. | | 24a. REC'D BY REGISTRAR FEB 23 1960 | |
| ADDRESS Wash., D.C. | | 24b. REGISTRAR'S SIGNATURE John J. Knauf | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02216

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| <i>Montgomery</i> <i>Kensington</i> | | a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> | | c. LENGTH OF STAY IN MD <i>5 years</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4406 Cawther Dr.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Helene</i> | Middle <i>B.</i> | Last <i>Morris</i> |
| 4. DATE OF DEATH | Month <i>Feb</i> | Day <i>12</i> | Year <i>1960</i> |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| <i>Female</i> | <i>White</i> | <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <i>12-23-1887</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i> | 11. BIRTHPLACE (State or foreign country) <i>D.C.</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Patrick Gleason</i> | 14. MOTHER'S MAIDEN NAME <i>Mary Stundson</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>None</i> | 17. INFORMANT <i>Francois Donohoe - I live 2</i> | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Influenza</i> DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> | | | |
| 5 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <i>2-12-60</i> |
| EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2/16/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i> | 22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | ADDRESS <i>Bethesda, Maryland</i> | 24a. REC'D BY REGISTRAR <i>C. H. S. Kraus</i> | 24b. REGISTRAR'S SIGNATURE <i>C. H. S. Kraus</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02217

2124 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore County</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore wrought 15 mos</i> | | c. LENGTH OF STAY IN lb <i>Le Decay Rest Home</i> | |
| d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>St. John's Hospital</i> | | e. STREET ADDRESS <i>End of Banana St</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Lam Elizabeth</i> | | 4. DATE OF DEATH <i>Murray 2 - 19 - 1960</i> | Month Day Year |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-26-88</i> |
| 9. AGE (In years last birthday) <i>71 yrs.</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Caretaker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp</i> | 10c. BIRTHPLACE (State or foreign country) <i>M. J.</i> |
| 11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 12. MOTHER'S MAIDEN NAME <i>Mary McAloney</i> | |
| 13. FATHER'S NAME <i>Edward Murray</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary McAloney</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT | |
| 17. MEDICAL CERTIFICATION PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | DUE TO <i>Hepatite jaundice Cirrhosis Liver</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month Day Year Hour o m p m 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Feb. 16, 1960</i> , to <i>Feb. 19, 1960</i> , that I last saw the deceased alive on <i>Feb. 16, 1960</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>Ridgemont Ave., Baltimore, Md.</i> | |
| ACTUAL SIGNATURE <i>Ruth T. Anderson</i> | | DATE SIGNED <i>3/1/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Ruth T. Anderson</i> | | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>2/21/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>St. John Cemetery</i> |
| 22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Huntress & Son</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 23 1960</i> | 24b. REGISTRAR'S SIGNATURE <i>Erving S. Krause</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2175

CERTIFICATE OF DEATH

02218

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE | Washington, D.C. b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Kensington | | | c. LENGTH OF STAY IN 1b | 11 Days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | Kensington Gardens Sanitarium | | | d. STREET ADDRESS | 6220 - 58th Ave. 16 Forest Hgts., Md. | | |
| 3. NAME OF DECEASED (Type or print) | First Nelle | Middle Mac | Last Murray | 4. DATE OF DEATH | Month February | Day 13 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | FEB. 11, 1893 | 9. AGE (In years last birthday) 67 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR | 10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Edward Casson | | | | 14. MOTHER'S MAIDEN NAME Mary Wood | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO None | INFORMANT MRS. EDNA NAVENTON | | | Address 6116 W. CHESTER DR. CAMP SPRINGS, MD. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Varices Portal Obstruction DUE TO (c) Abdominal Carcinomatosis Ovarian Carcinoma, Primary | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 48 hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from Dec 29, 1959, to Feb 13, 1960, that I last saw the deceased alive on February 13, 1960, and that death occurred at 6:00 PM, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE | Robert T. Thibadeau, M.D. 10609 Concord Street, Feb. 13, 1960 | | | | | | |
| PHYSICIAN'S NAME (Type) | Robert T. Thibadeau, M.D. Kensington, Maryland | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-16-60 | 22c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet | 22d. LOCATION (City, town, or county) Washington D.C. (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C. | | | 24a. REC'D BY REGISTRAR DATE FEB 16 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

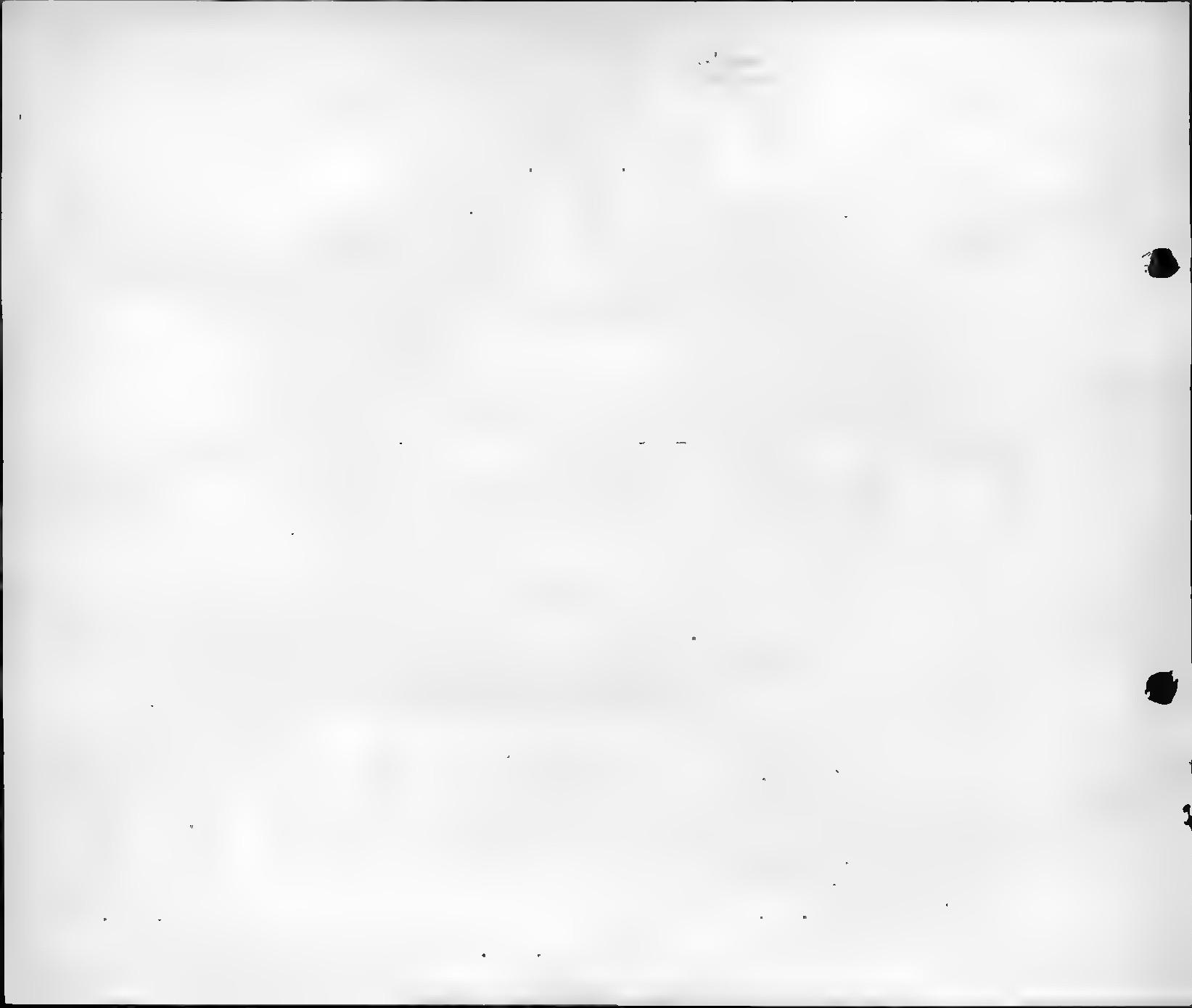
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02219

2253

| | | | | | | | | | |
|---|--|---|---|--|--|--|--------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE MARYLAND | | b. COUNTY HOWARD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 21 HR. 15 MIN. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. AIRY | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. | | | | d. STREET ADDRESS RT. #3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HARRISON | | First | Middle | Last | 4. DATE OF DEATH FEBRUARY 24 1960 | Month | Day | Year | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 1/4/87 | 9. AGE (in years last birthday) 73 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME CHARLES ALLEN MYERS | | | | 14. MOTHER'S MAIDEN NAME HENRIETTA FISHER | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-03-0554 | | 17. INFORMANT HOSPITAL RECORDS | | Address OLNEY, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | ACUTE CARDIAC FAILURE | | | | INTERVAL BETWEEN ONSET AND DEATH 36 HRS. | | | |
| 470 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | ARTERIOSCLEROTIC HEART DISEASE | | | | 5 YRS. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA - 1 WK. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from FEB. 23 1960 , to FEB. 24 1960 , that (I) (we) last saw the deceased alive on FEB. 24 1960 , and that death occurred 10:15A from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Openther, M.D.</i> | | M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED FEB. 25, 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D. | | | | 22d. ADDRESS CLARKSVILLE, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb. 27, 1960 | | 23c. NAME OF CEMETERY OR CREMATORIAL Simpson Methodist | | 23d. LOCATION (City, town, or county) Poplar Springs, Md. | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Molsworth</i> | | ADDRESS Damascus, Md. | | 25a. REC'D BY REGISTRAR DATE FEB 29 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

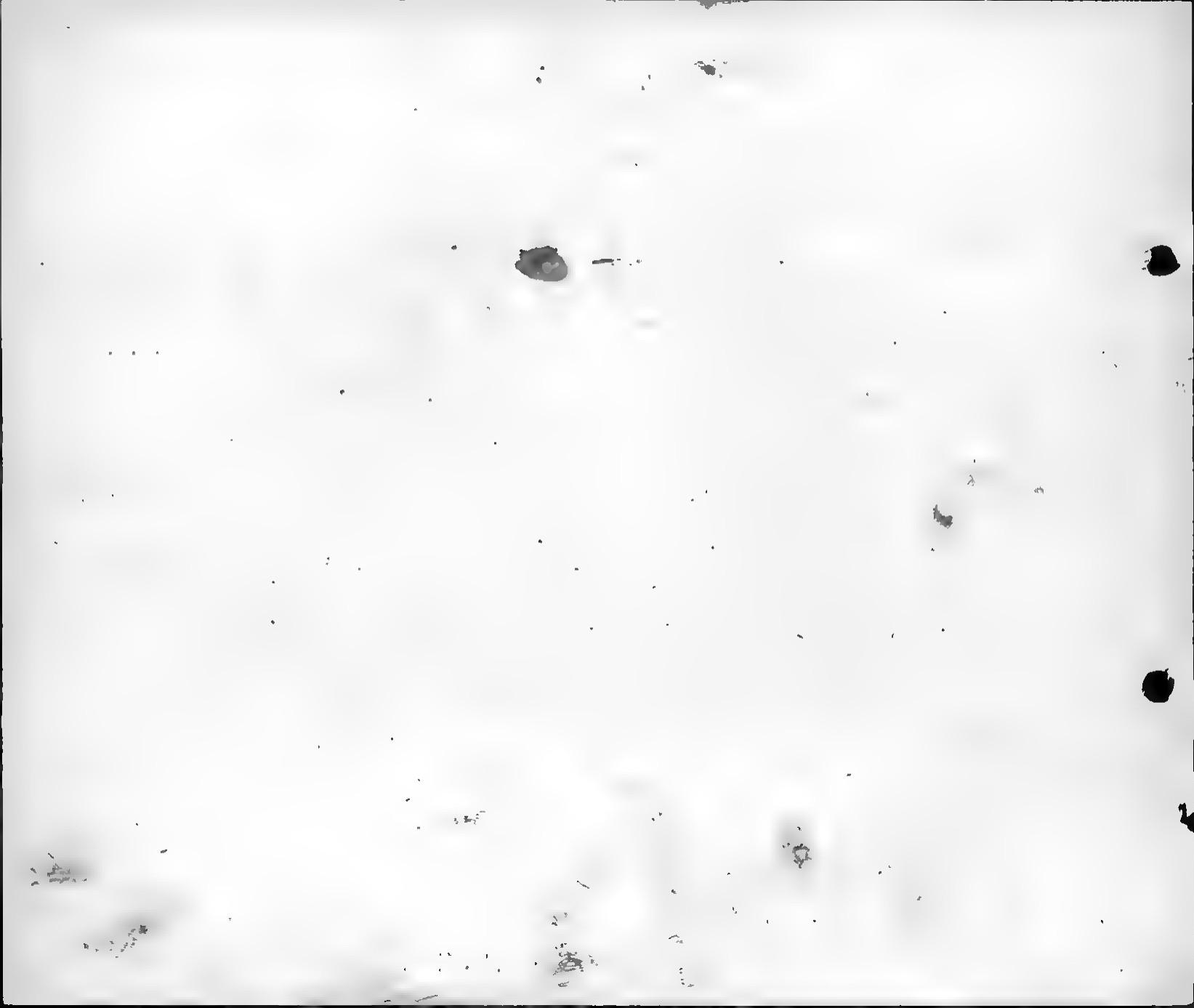
Item 8 fil. G218 3-9-60 et

02220

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 25 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria | |
| 3. NAME OF DECEASED (Type or print) Rebecca | | First A. | Middle Nebel |
| 4. DATE OF DEATH 2 22 1960 | | Month 2 | Day 22 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| | | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 2/26/74 | | 9. AGE (In years last birthday) 36 yrs | 10. IF UNDER 1 YEAR Months 36 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Ohio |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Wurpel | |
| 14. MOTHER'S MAIDEN NAME Sarah Sanders | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | INFORMANT Husband | Address as above |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. Death was caused by immediate cause (a) 578 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Conpressive pulmonary atelectasis DUE TO (c) Consciousness, and hypotension INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown Unknown | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Ulcerative colitis; Status post-operative rectosigmoid colostomy | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Describe how injury occurred (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb 14 , 1960, to Feb 22 , 1960, that I last saw the deceased alive on Feb 22 , 1960, and that death occurred at 12:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) John C. Murphy M.D. 1801 EYE St NW Washington, DC ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) John Murphy DATE SIGNED | | | |
| 22a. BURIAL/CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 26, 1960 | 22c. NAME OF CEMETERY OR CREMATORIUM Brown |
| 22d. LOCATION (City, town, or county) Colesburg, Iowa | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Barry Mountcastle | | | |
| ADDRESS Cunningham Funeral Home Inc. Cameron and Alfred Sts. Alex. Va. | | 24a. REC'D BY REGISTRAR FEB 24 '60 | 24b. REGISTRAR'S SIGNATURE Charles S. Knott |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02221

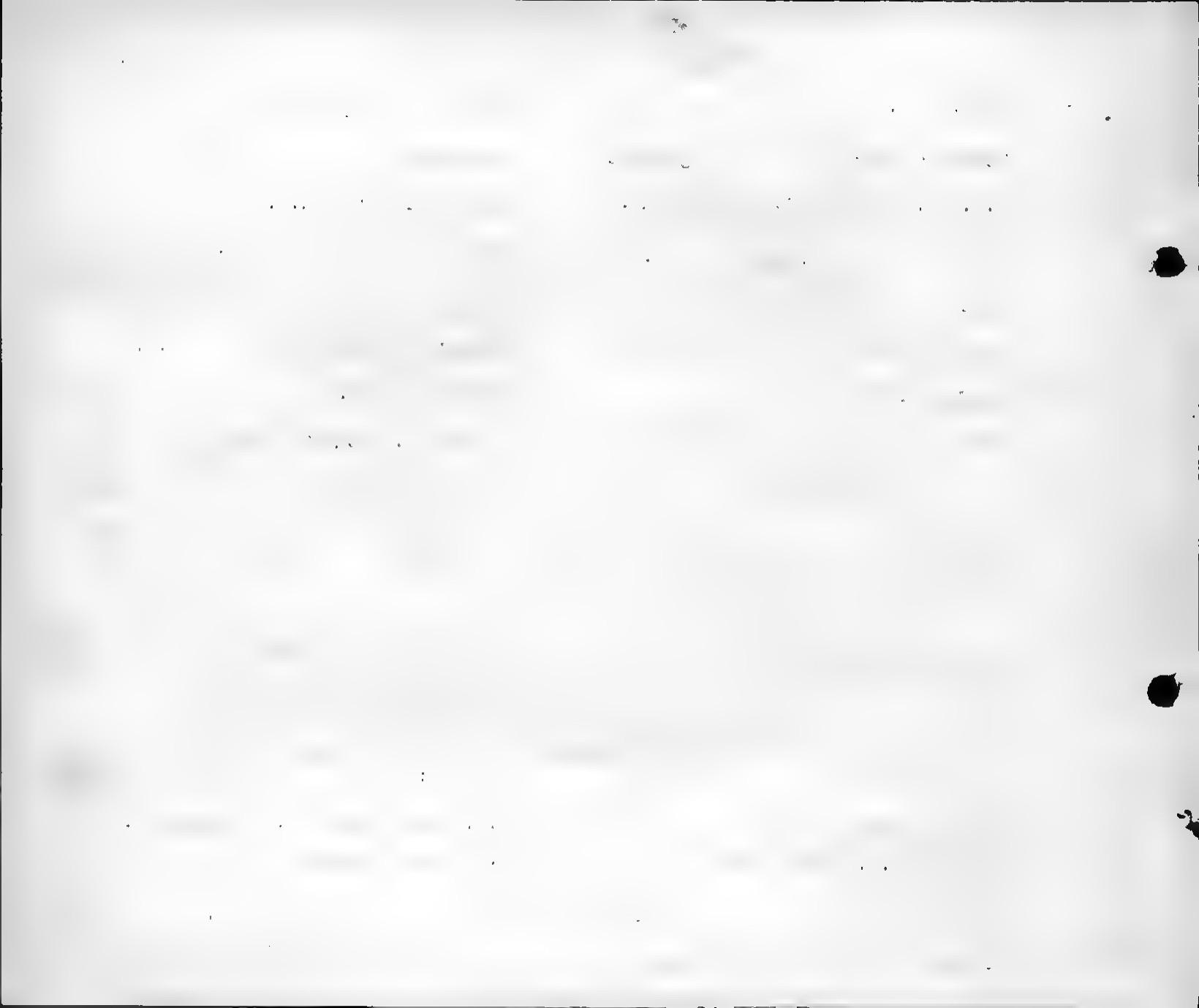
2255 CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH o COUNTY Montgomery | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE District of Columbia | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c LENGTH OF STAY IN 1b 35 days | | d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Alan G. NICHOLS | | First | Middle | Last | 4. DATE OF DEATH Month February 27 |
| 5. SEX Male | | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-29-93 | 9 AGE (In years last birthday) 67 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (State or foreign country) District of Columbia | |
| 13. FATHER'S NAME George NICHOLS | | 14. MOTHER'S MAIDEN NAME Frances GAITHER | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 579-09-6653 | | INFORMANT (Son) Eugene C. NICHOLS | Address Same as #2 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO <i>420.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <i>Arteriosclerotic heart disease</i> DUE TO <i>years</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 23 January 1960 , to 27 February 1960 , that I last saw the deceased alive on 27 February 1960 , and that death occurred at 10:00 AM from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-29-60 | | | | | |
| ACTUAL SIGNATURE <i>James M. Young</i> | | | | | |
| PHYSICIAN'S NAME (Type) J. M. YOUNG LT MC USN | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-2-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Gartner</i> | | ADDRESS Gaithersburg, Maryland | | 24a. REC'D BY REGISTRAR MAR 2 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |



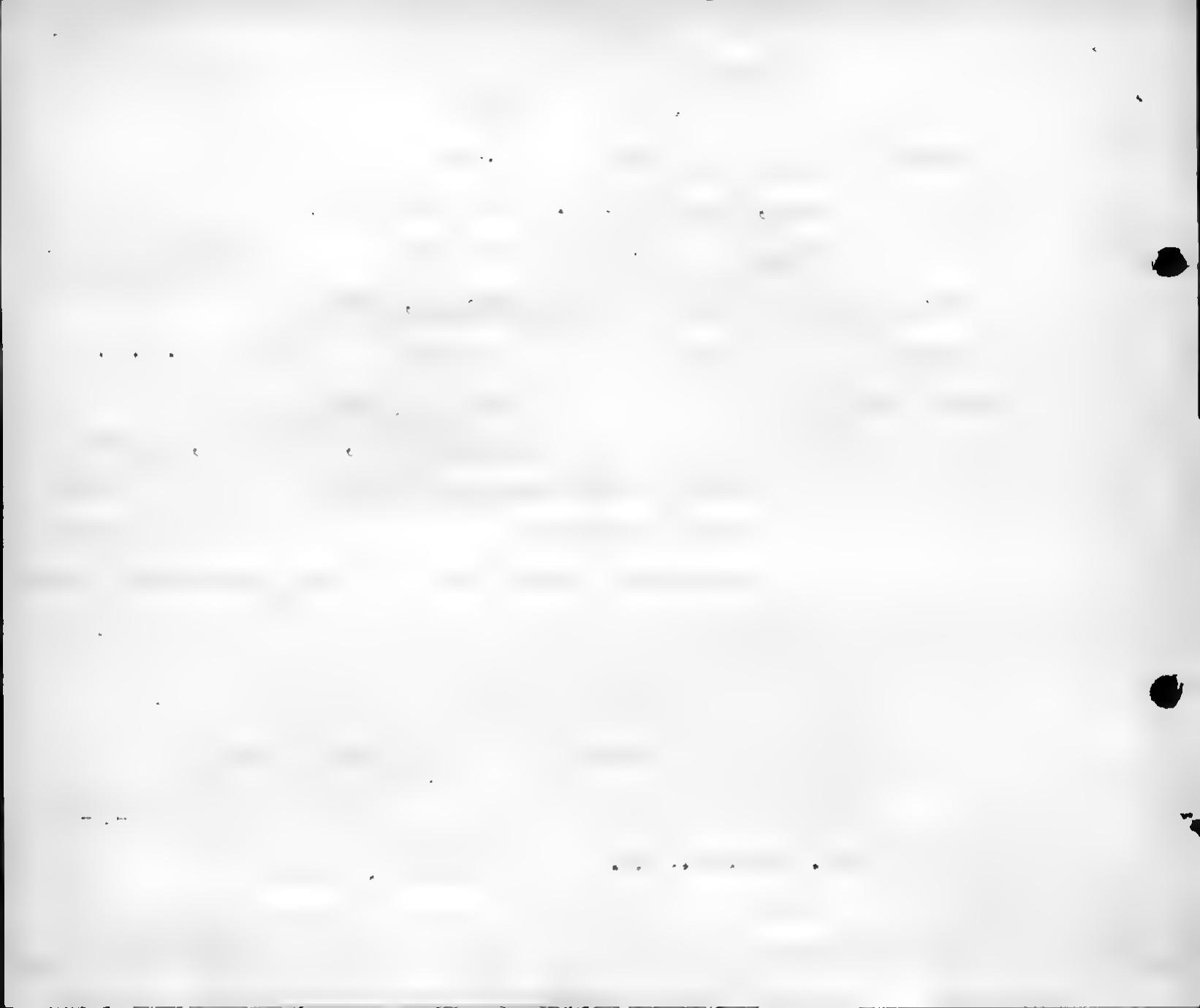
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02222

Reg. Dist. No.

| | | | | | | |
|--|----------------------------------|--|---|--|----------|---------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Florida | | | | |
| c. LENGTH OF STAY IN 1b RURAL and give nearest town) Bethesda | | d. C. T.Y OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orlando | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. STREET ADDRESS 1101 Nottingham Avenue | | | | |
| 3. NAME OF DECEASED (Type or print) | First Minerva | Middle (None) | 4. DATE OF DEATH February 15 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH February 19, 1905 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | 9. AGE (In years last birthday) 54 yrs | | | |
| 10c. BIRTHPLACE (State or foreign country) New York | | 11. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 13. FATHER'S NAME Samuel Bykowsky | | 14. MOTHER'S MAIDEN NAME Lena Raphaelson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | | | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Right pyelonephritis DUE TO (c) Carcinoma of adrenal cortex with extensive metastasis 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH hours days | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from December 13, 1959 , to February 15, 1960 , that I last saw the deceased alive on February 15, 1960 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) John L. Lewis, Jr., M.D. M.D. The Clinical Center DATE SIGNED 2-15-60 | | | | | | |
| ACTUAL SIGNATURE John L. Lewis, Jr. | | | | | | |
| PHYSICIAN'S NAME (Type) John L. Lewis, Jr., M.D. M.D. The Clinical Center DATE SIGNED 2-15-60 | | | | | | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 2/17/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematory | 22d. LOCATION (City, town, or county) Suitland, Maryland | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR DATE FEB 16 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |



02223

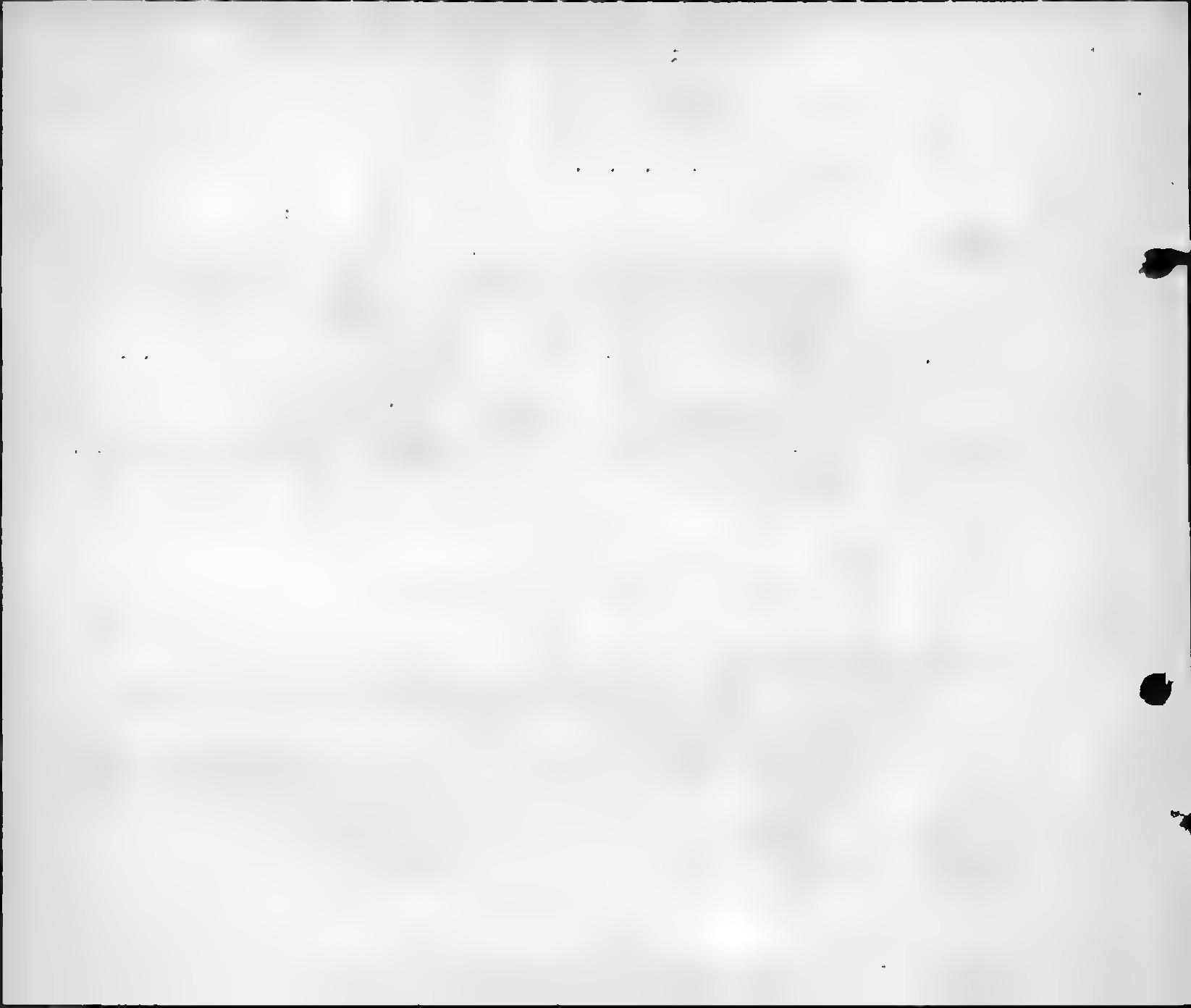
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | |
|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | Montgomery 2257 MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | a. STATE Maryland | b. COUNTY Montgomery |
| Bethesda | | D. O. A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | Kenington | | |
| Suburban Hospital | | d. STREET ADDRESS | 3817 Decatur Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH |
| Daisy | | Nycinth | Norris | February 14, 1960 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | I900 |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | September 1, 1900 | 9. AGE (in years last birthday) 59 65 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| Hawf. | | ----- | | Virginia |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| Frank Crist | | Lily B. Witt Witt | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | Address |
| | | None | | Della Fram (daughter) 930 Emerson, Wash. D.C. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestion heart failure</i> 1 day 241X Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchial Asthma</i> 2 yrs DUE TO (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 19 | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE <i>Frank J. Borschent</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED 2-18-60 |
| EXAMINER'S NAME (Type) <i>Frank J. Borschent</i> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/18/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Rockville Cemetery | 22d. LOCATION (City, town, or county) Rockville, Maryland | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland | ADDRESS | 24a. REC'D BY REGISTRAR FEB 16 '60 | 24b. REGISTRAR'S SIGNATURE Gathering & Sons | |

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



X
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21202

215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | Item # File#237 2-22-60 | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park | c. LENGTH OF STAY IN lb YEARS | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7137 Maple Ave | d. STREET ADDRESS 7137 Maple Ave | e. IS RESIDENCE ON A FARM? 1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Axel A. Ostrom | First M dd e Last | 4. DATE OF DEATH Feb. 23, 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/20/1887 | 9. AGE (in years last birthday) 72 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Finland | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Arvid Ostrom | 14. MOTHER'S MAIDEN NAME Engman | Address Item 2 | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank and dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Greta S. Ostrom | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO (c). | INTERVAL BETWEEN ONSET AND DEATH Budden | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | 20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J Broschart | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | DATE SIGNED Feb. 23, 1960 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb. 23, 1960 | 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ADDRESS Arthur Stollers 254 Carroll St. N.W. D.C. | 22d. LOCATION (City, town, or county) WASL 12 22e. REC'D BY REGISTRAR D.FEB 25 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | |
| VS. A15ME SM 7/59 | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

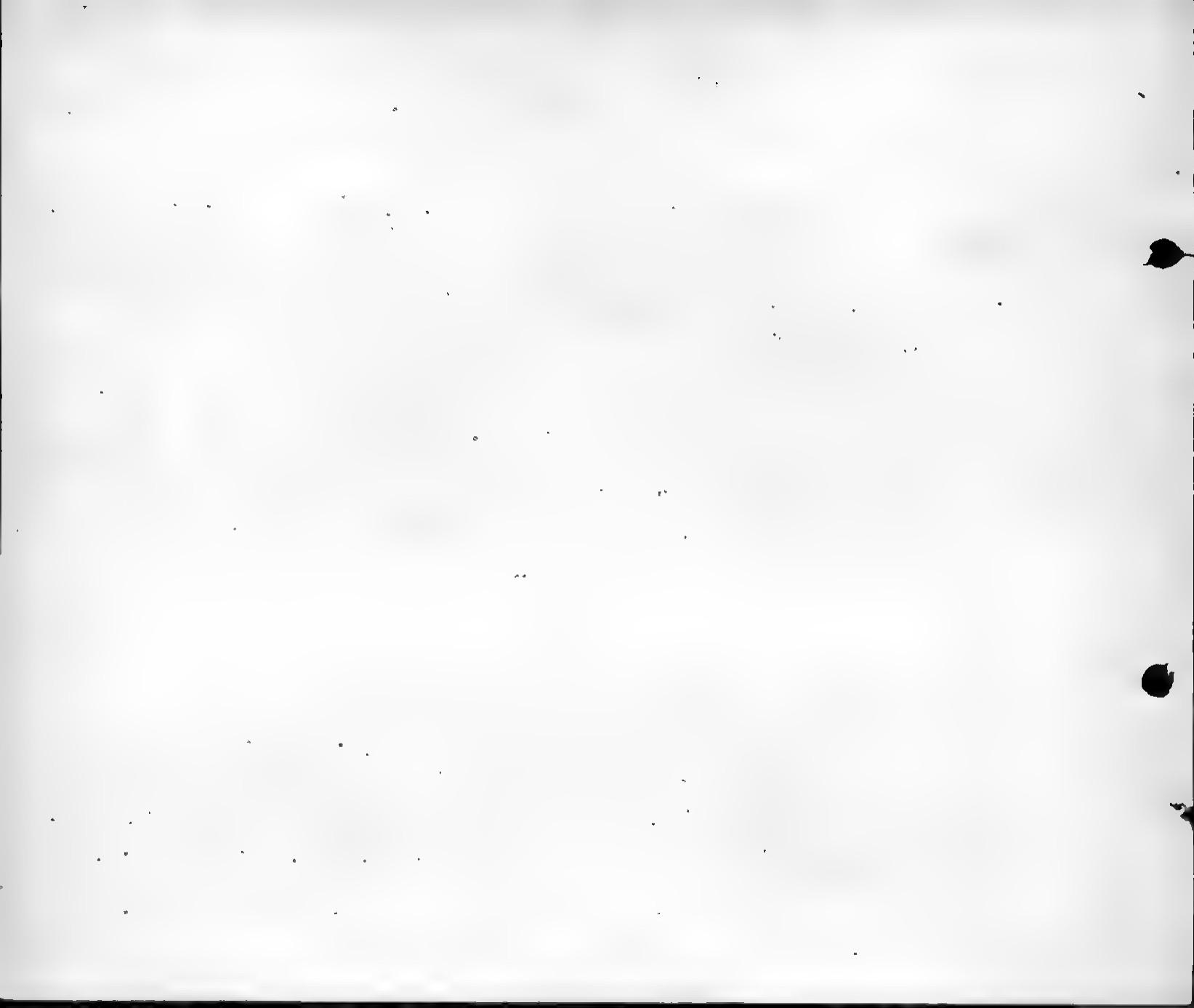
2258 CERTIFICATE OF DEATH

Reg. Dist. No.

02225

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE | | | |
| Montgomery MARYLAND | | Md. Mont. Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | b. COUNTY | | | |
| Bethesda | 7 days | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | d. STREET ADDRESS | | | | |
| Tuburban | 17613-Cayuga Ave | | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | | |
| Anne | J | M. | Pachuta | | |
| 5. SEX | 16. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | | |
| Female white | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Jan 4 1881 | 9. AGE (In years last birthday) | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| Homemaker | | Austria | U.S.A. | | |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| Paul Marinak | Anna Wellington | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | INFORMANT | Address | | |
| No | none | Anne Pachuta - daughter | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | | | | |
| 332X DUE TO BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 4 DAYS | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | | | | |
| (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE 1 MONTH | | | | | |
| (c) DUE TO CEREBRAL THROMBOSIS AND HEMIPLEGIA, RT. 4 MONTHS | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from NOV. 1959, to FEB. 14, 1960, that I last saw the deceased alive on FEB. 14, 1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above | | | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE | | Leo M. Curtis | | M.D. 8218 WISCONSIN AVE., BETHESDA, MD 20814 8218 Wisc. Ave. Bethesda, Md. 20814 | |
| PHYSICIAN'S NAME (Type) | | Leo M. Curtis | | 8218 Wisc. Ave. Bethesda, Md. | |
| 22a. BURIAL CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/18/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery | |
| | | | | 22d. LOCATION (City, town or county) Mt. Carmel, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | |
| | | | | 24a. REC'D BY REGISTRAR FEB 16 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Albert S. Krause | |



TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 20 Film 257 2nd 1965

02226

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>D.C.</i> | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington Park</i> | | b. COUNTY | | | | | | | | | | | |
| c. LENGTH OF STAY IN 1b <i>10 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash Sanitarium & Asyf</i> | | d. STREET ADDRESS <i>737 Aspen St. N.W.</i> | | | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 47 | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Grace Gladmon Pearce</i> | | First <i>Grace</i> | Middle <i>Gladmon</i> | | | | | | | | | | |
| 4. SEX <i>Female</i> | | 5. COLOR OR RACE <i>White</i> | 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>6-3-1875</i> | | | | | | | | | | |
| 7. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bureau of Vital Statistics (retired)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | | | | | |
| 13. FATHER'S NAME <i>Barney K. Gladmon</i> | | 14. MOTHER'S MAIDEN NAME <i>Eliza E. Duley</i> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>none</i> | | | | | | | | | | | |
| 17. INFORMANT <i>Hof record</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>902.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Bremer - pneumonia</i> | | | | | | | | | | | |
| | | DUE TO (b) <i>Fracture left big</i> | | | | | | | | | | | |
| | | DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Fell off chair to floor at home</i> | | 20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 2-3-60 19</i> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | | 20f. (City or town) (County) (State) <i>Washington</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | 22. ACTUAL SIGNATURE <i>Frank J. Borschert</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <i>2-13-60</i> | |
| EXAMINER'S NAME (Type) <i>Frank J. Borschert</i> | | 22b. DATE THEREOF <i>2/16/60</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i> | | 22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> | | (State) | | | | | |
| 22e. BURIAL CREMATION REMOVAL (Specify) <i>burial</i> | | 22f. ADDRESS <i>3401-14th St. N.W. Washington, D.C.</i> | | 24a. REC'D BY REGISTRAR <i>FEB 16 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Hines & Son</i> | | 24c. DATE | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File #2-6 2-2-60 et

02227

CERTIFICATE OF DEATH

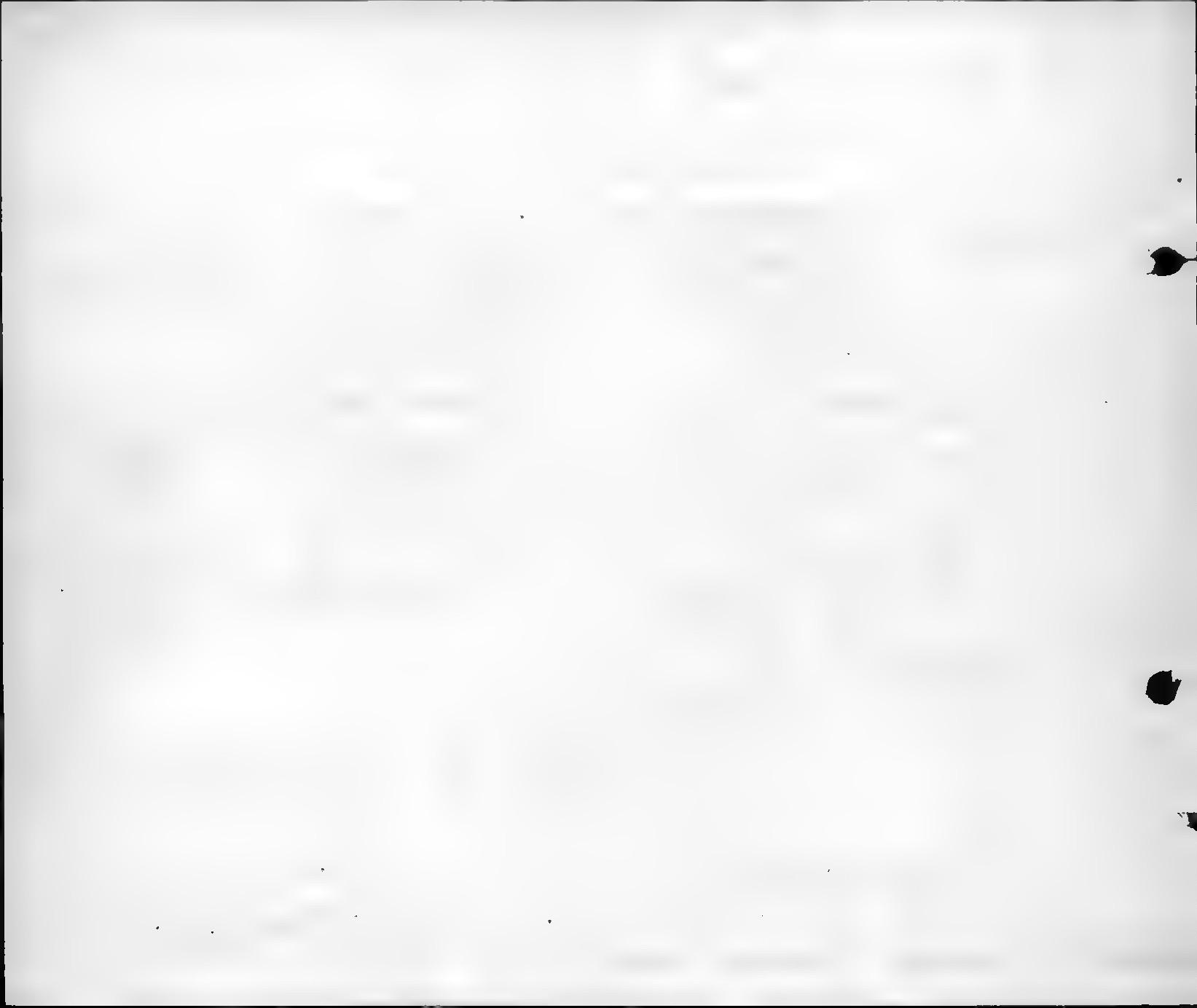
Reg. Dist. No.

| | | | | | |
|---|-------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY | | 2259 MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 5 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BROOKEVILLE | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. RT. #1 Box #159 | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First MARGARET | Middle ELLEN | Last PEARCE | 4. DATE OF DEATH FEBRUARY 1 19 60 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/9/83 | 9. AGE (In years last birthday) 776 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) VIRGINIA | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WESTLYN DAVIS | | 14. MOTHER'S MAIDEN NAME JOSEPHINE ROBERTS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — | | 16. SOCIAL SECURITY NO NONE | INFORMANT HOSPITAL RECORDS | Address OLNEY, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured heart DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO (c) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 days 6 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from _____, 1956, to 2/1/1960, that I last saw the deceased alive on 2/1/1960, and that death occurred at 4:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>C. H. Ligon, M.D.</i> DATE SIGNED 2/1/60 | | | | | |
| PHYSICIAN'S NAME (Type) C. H. LIGON, M.D. | | SANDY SPRING, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-3-60- | 22c. NAME OF CEMETERY OR CREMATORIUM Salem Meth. Cemetery | 22d. LOCATION (City, town, or county) Brookeville Md. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frances L. Barber Laytonville Md.</i> | | 24a. REC'D BY REGISTRAR DATE FEB 4 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15(4)
15M 9/58



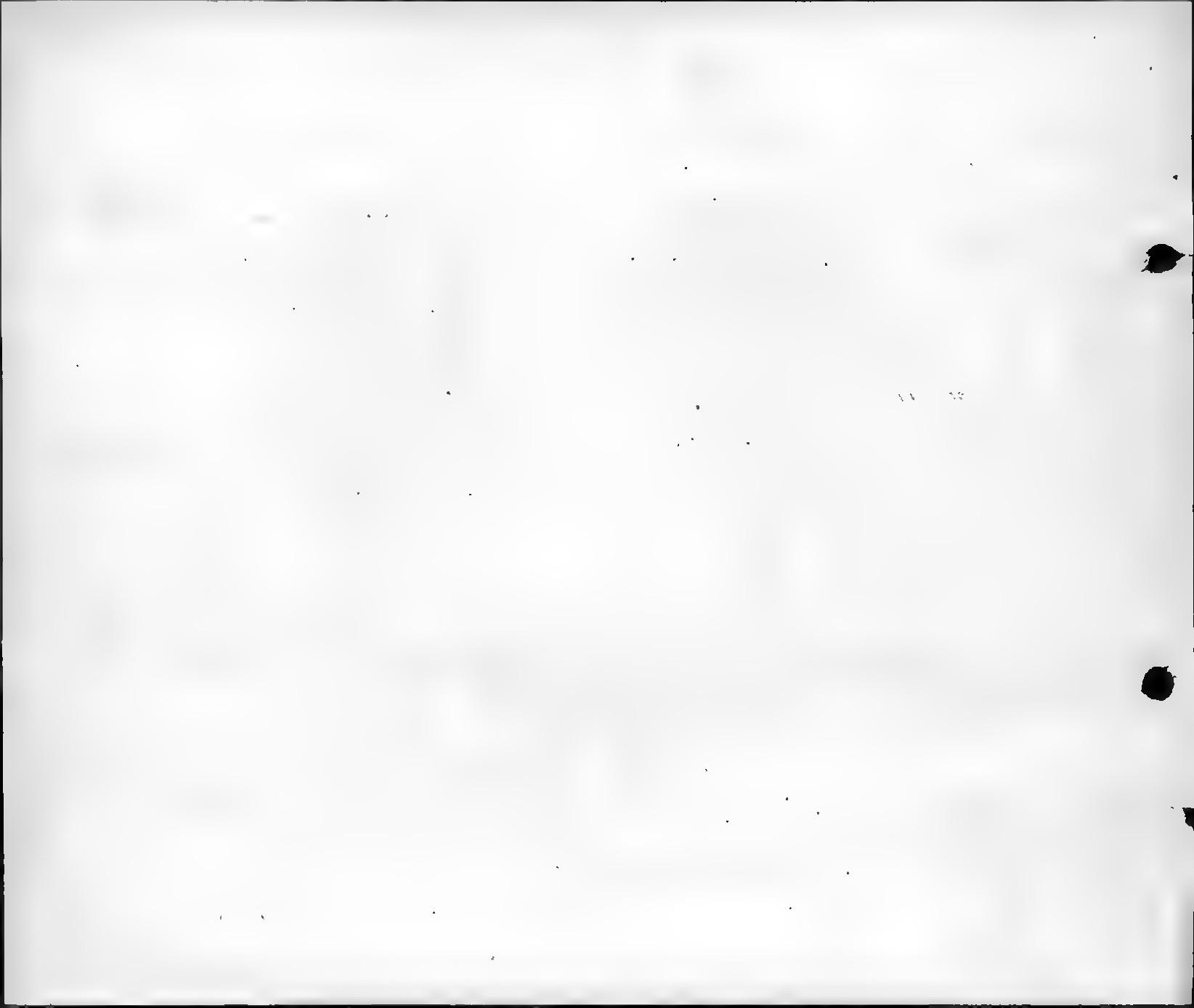
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02228

2260 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | | | | |
| <i>Montgomery</i> | | a. STATE | <i>Maryland</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Alta Vista Nursing Home</i> | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <i>Edna</i> | Middle <i>V. T.</i> | 4. DATE OF DEATH Lost <i>Peters</i> | Month <i>Feb</i> | Day <i>1</i> | Year <i>1960</i> |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Aug 28 1877</i> | 9. AGE (In years lost birthday) <i>82</i> | 10. IF UNDER 1 YEAR Months <i>5</i> | 11. IF UNDER 24 HRS Days <i>1</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i> | | |
| 13. FATHER'S NAME <i>John</i> | | 14. MOTHER'S MAIDEN NAME <i>Catherine Dare</i> | | Address <i>Bethesda, Md</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO <i>None</i> | | INFORMANT <i>J. Graham Peters</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>years</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</i> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NONE</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <i>a. m.</i> <i>p. m.</i> | | Month <i>19</i> | Doy. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | 20f. (City or town) <i>5:38 AM</i> | (County) (State) |
| 21. I certify that I attended the deceased from <i>1958</i> , to <i>Feb 1, 1960</i> , that I last saw the deceased alive on <i>JAN 27, 1960</i> , and that death occurred at <i>5:38 AM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>DeWitt E. Lester</i> ADDRESS (Street, city or town, state) <i>8025 ABERDEEN Rd. Bethesda MD</i> DATE SIGNED <i>2/1/60</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>DeWitt E. Lester, M.D.</i> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>1-4-60</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Cemetery Friends Meeting House</i> LOCATION (City, town, or county) (State) <i>Sandy Spring, Maryland</i> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | | |
| VS A15 (4) ISM 9/58 | | DATE <i>FEB 4 '60</i> | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2b Form 625 5-6-60 et

CERTIFICATE OF DEATH

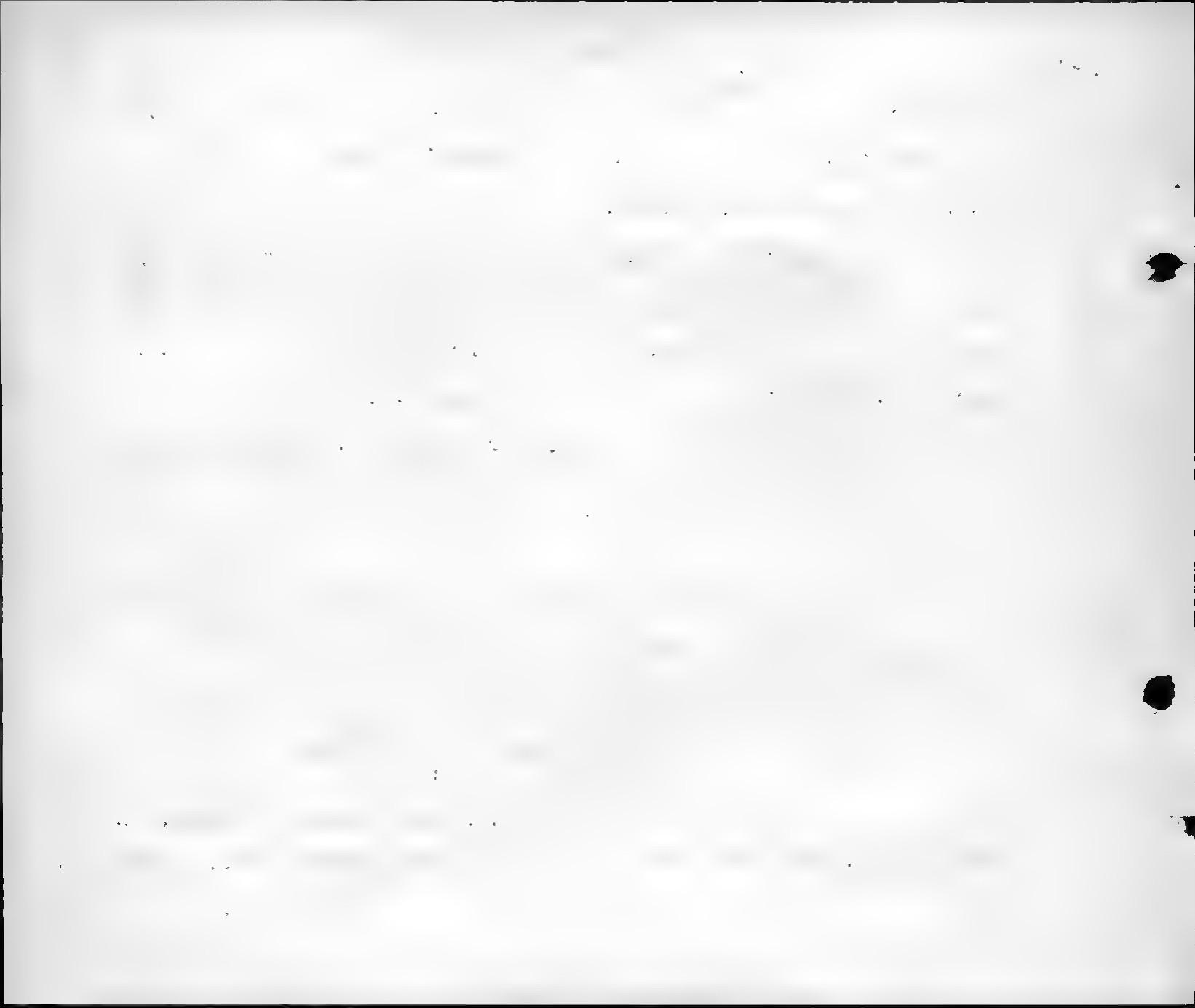
Reg. Dist. No. 215

112229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH COUNTY Montgomery | 2261 | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission on) a. STATE Maryland | b. COUNTY Clarendon | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | c LENGTH OF STAY IN lb 1 hour | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Manor | d. STREET ADDRESS 22 Edgewood Road | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Roger | First Gordon | Middle POCHUREK | 4. DATE OF DEATH February 29 1960 | Month Day Year | |
| 5. SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2-7-60 | 9. AGE (In years last birthday) yrs. 22 | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Lawrence M. POCHUREK | | | 14. MOTHER'S MAIDEN NAME Shirley J. KAPPEN | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (Father) Lawrence M. Pochurek Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | DUE TO 752X | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last | | (b) DUE TO Brain damage | | 4 wks | |
| | | (c) Hydrocephaly | | 4 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 29 February, 1960, to 29 February, 1960, that I last saw the deceased alive on 29 February, 1960, and that death occurred at 1:50P.M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>G.B. Avery</i> | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3-3-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | |
| 22d. LOCATION (City, town, or county) Arlington Va. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE MAR 3 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Frank</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

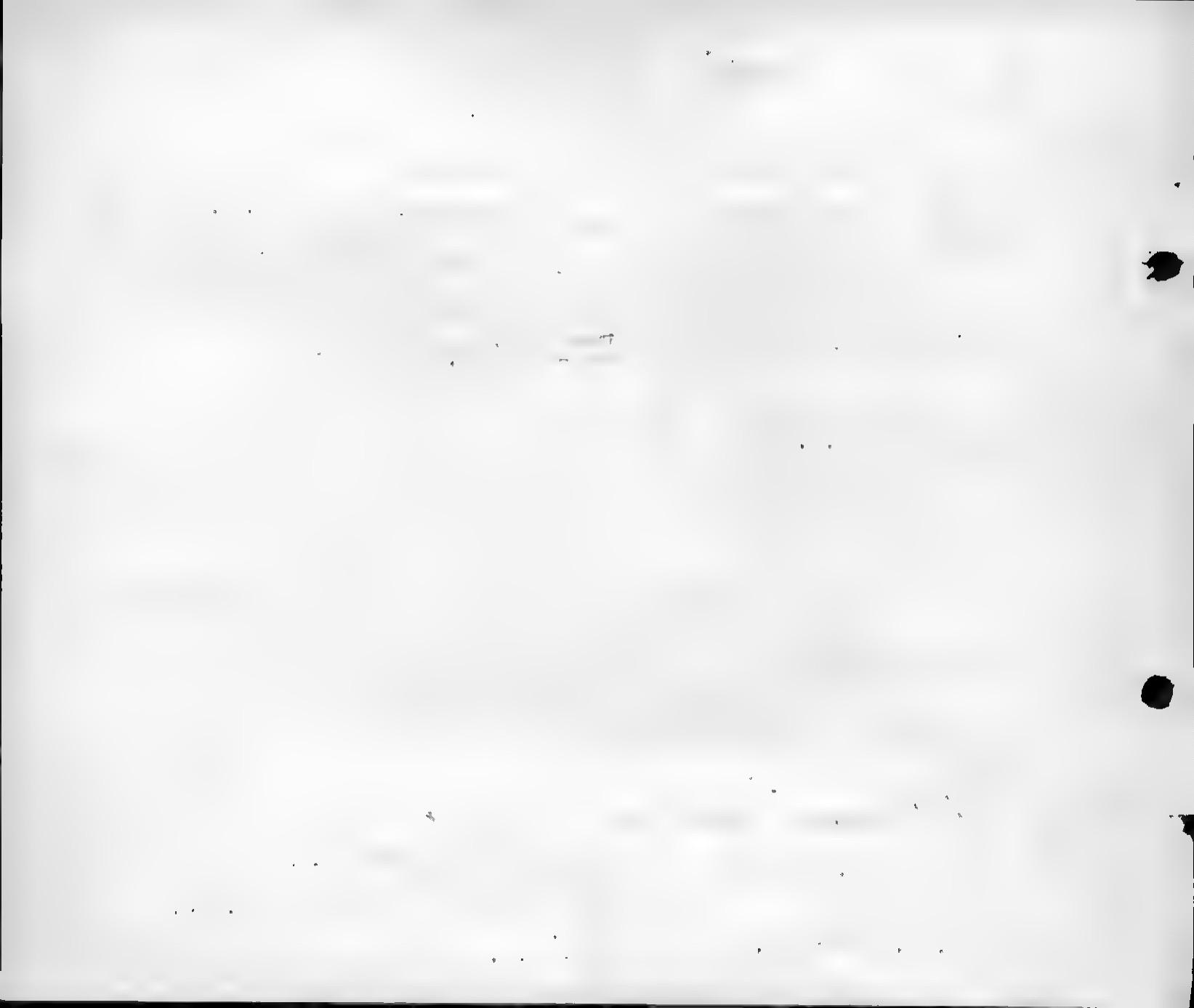
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02230

2262

| | | | | | |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE WASHINGTON, D. C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 5 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41X | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. | | d. STREET ADDRESS 6688 32nd PLACE, N. W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JESSE ELLIS | | First | Middle | Last | 4. DATE OF DEATH FEBRUARY 24 19 60 |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 5/13/95 | 9. AGE (in years last birthday) 64 yrs IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. JS/JAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Chief of Domestic Parts Corp. of Engineers USA | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C. | | 11. BIRTHPLACE (State or foreign country) USA | |
| 13. FATHER'S NAME ELLIS PORTER | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO W.W. I | | 17. INFORMANT HOSPITAL RECORDS ANNIE SHERWOOD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | CEREBRAL HEMORRHAGE | | Address OLNEY, MD. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH 9 DAYS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from FEBRUARY 15 1960 , to FEBRUARY 24 1960 , that (I) (we) last saw the deceased alive on FEB. 23 19 60 , and that death occurred 8:10A , from the causes and on the date stated above | | 21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 22a. SIGNATURE William C. Miller | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM C. MILLER, M. D. | | 22d. ADDRESS GAITHERSBURG, M. D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/26/60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery | |
| 23d. LOCATION (City, town, or county) Washington, D.C. | | (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St., N.W. | | ADDRESS Wash. DC | | 25a. REC'D BY REGISTRAR DATE FEB 25 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Knapp | |

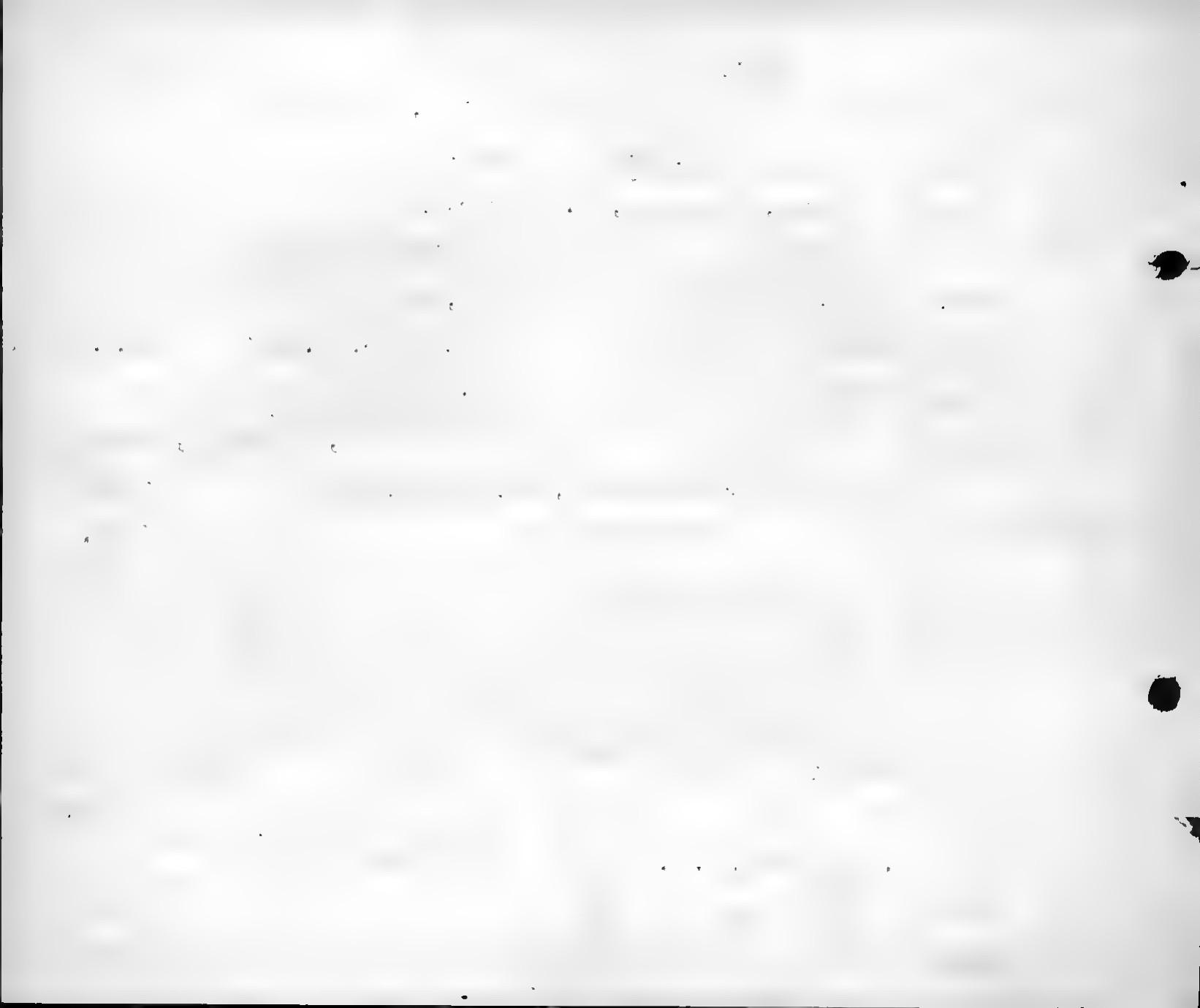


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02231

| | | | |
|---|--|--|---|
| 2263 | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| a. COUNTY Montgomery | | a. STATE Peru, South America | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | b. COUNTY Iquitos | |
| c. LENGTH OF STAY IN 1b 11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arica 132 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Bella | | First | Middle |
| | | | lost |
| | | | Prentice |
| 4. DATE OF DEATH February 25 | | Month | Day |
| | | Year | 1960 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 11, 1953 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student) | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Lima, Peru, So. America |
| 12. CITIZEN OF WHAT COUNTRY? Peru, S. America | | | |
| 13. FATHER'S NAME Carlos Prentice | | 14. MOTHER'S MAIDEN NAME Bella Tuchia | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO (d) DUE TO Tetralogy of fallot | | 6 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 14, 1960, to February 25, 1960, that I last saw the deceased alive on February 25, 1960, and that death occurred at 4:15 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| ACTUAL SIGNATURE <i>E. Kent Carney</i> | | DATE SIGNED 2/26/60 | |
| PHYSICIAN'S NAME (Type) E. KENT CARNEY, M. D. | | M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP | | 22b. DATE THEREOF 3-13-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 1400 Chapin Street, Washington, D.C. | | 22d. LOCATION (City, town, or county) IQUITOS PERU SO. AMERICA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Chambers C | | 24a. REC'D BY REGISTRAR DATE MAR 1 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Cynthia S. Kansas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2264

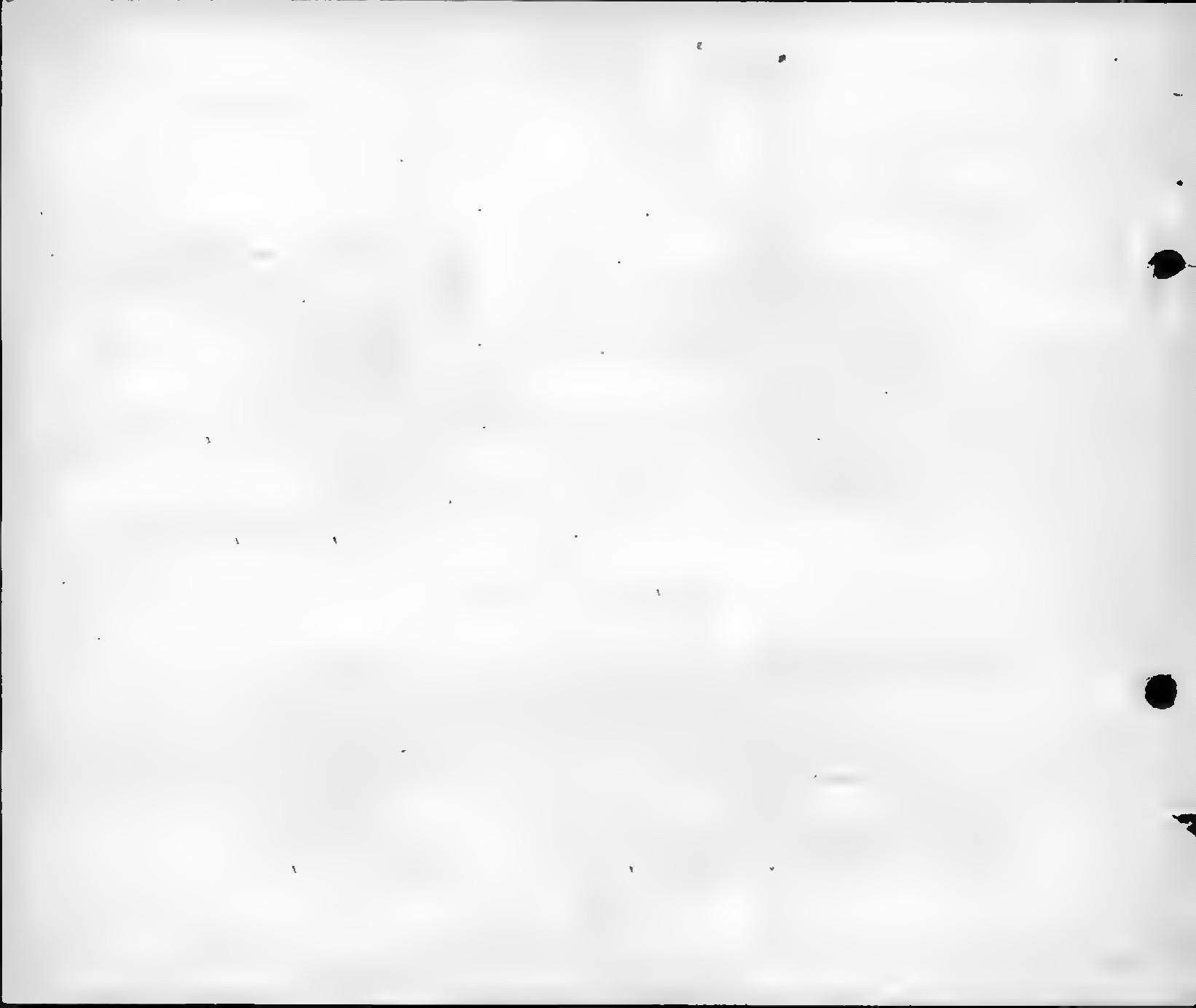
CERTIFICATE OF DEATH

Reg. Dist. No.

02232

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookeville | |
| c. LENGTH OF STAY IN 1b 14 days | | d. STREET ADDRESS Box 113 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Roy | Middle Buearl | Last Puckett |
| 4. DATE OF DEATH | Month February | Day 6 | Year 19 60 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-6-1910 |
| 9. AGE (In years last birthday) 49 yrs | | 10. UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Montg. Co. Tree Div. | |
| 10c. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sam Joseph Puckett | | 14. MOTHER'S MAIDEN NAME Taves May Stevebsib | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. WW 11 230-14-289 | |
| 17. INFORMANT Mildred B. Puckett | | Address Box 113, Brookeville Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 162.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last } (b) DUE TO (c) Bronchogenic Carcinoma Right Lung with metastases to left lung, liver, lymph nodes, and vertebrae INTERVAL BETWEEN ONSET AND DEATH six mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 Not white p. m. at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 18, 59 to Feb. 7, 1960 that I last saw the deceased alive on February 6, 19 60 , and that death occurred 10:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles S. Whitaker, M.D. | | ADDRESS (Street, city or town, state) Clarksville, Maryland | |
| PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/10/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home | | ADDRESS 1331 E. Montg. Rockville, Md. | |
| | | 24a. REC'D. BY REGISTRAR A FEB 9 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02253

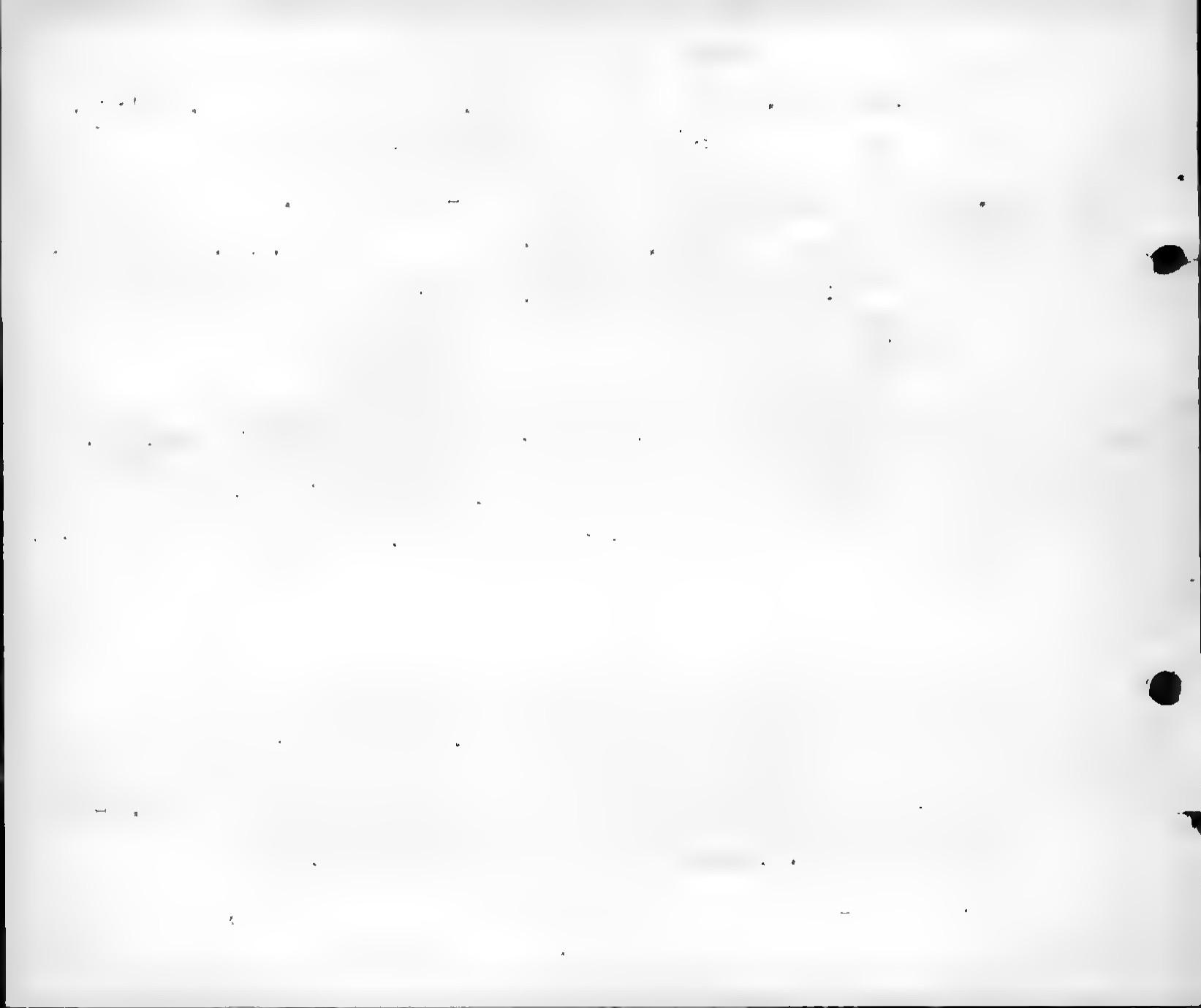
2265 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|--|---|--|-----------------------------------|---|---|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery Co. | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck | | c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Pr. Geo's Co. | |
| | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena Nursing Home | | | | d. STREET ADDRESS 7609 - Gateway Blvd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First | Middle B. | Last PUMPHREY | 4. DATE OF DEATH Feb. 8th. | | Month | Day | Year 19 60 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 24th 1890 | | 9. AGE (In years for birthday) 69 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Mollie Soper | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO No | | INFORMANT Mrs. Marian Ellis | | 7609-- ^{Address} District Heights, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | DUE TO (b) Generalized Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH one week | | | | | |
| Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | |
| 19. MEDICAL CERTIFICATION | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Cherry Chase, Md. (County) Washington, DC (State) MD | | | |
| 21. I certify that I attended the deceased from Jan 6, 1960 , to February 8, 1960 , that I last saw the deceased alive on Feb 8, 1960 , and that death occurred at 5:30 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 5527 Surrey St., Cherry Chase, Md. | | | | | | DATE SIGNED Feb. 8-1960 | |
| ACTUAL SIGNATURE <i>HARRY J. KICHERER</i> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) HARRY J. KICHERER | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-11-60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery | | 22d. LOCATION (City, town or county) Washington, DC | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Sinclair Bros</i> | | ADDRESS 1661-Good Hope Rd., SE Washington 20 DC | | 24a. REC'D BY REGISTRAR DATE FEB 10 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimerer</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

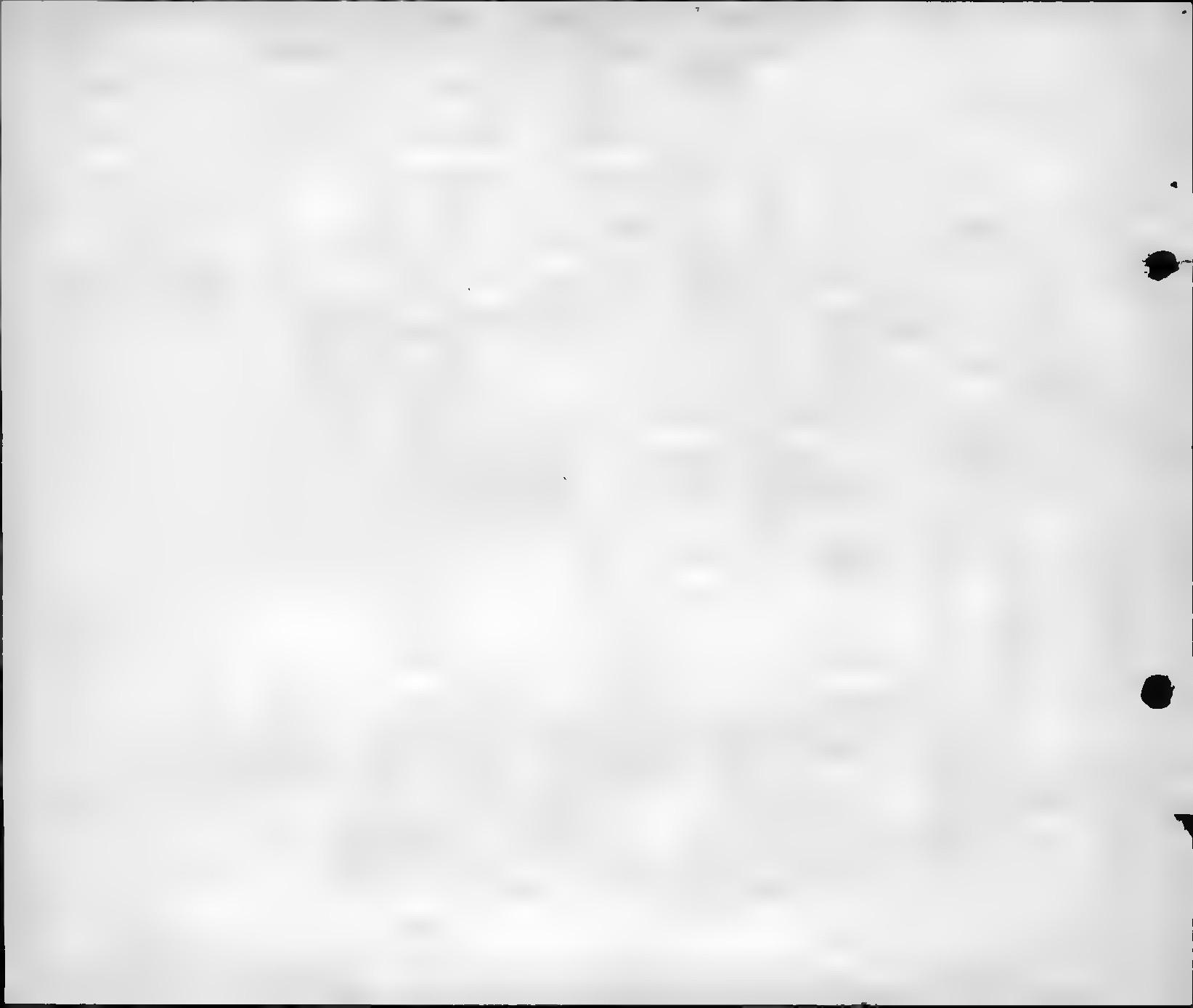
Reg. Dist. No.

112234

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE New Jersey b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 2266 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6912 Barret Ave | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Verona | |
| 3. NAME OF DECEASED (Type or print) AUGUSTA | | 4. DATE OF DEATH Feb 21 1960 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb 12 1898 | |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during past 6 months, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Abraham Cohen | | 14. MOTHER'S MAIDEN NAME Rose Soper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Sanford Slavin | | Address Ited Id (Son In Law | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | DATE SIGNED 2-21-60 | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-23-60 | |
| 22c. NAME OF CEMETERY OR CEMINATORY KING DAVID MEMORIAL GARDEN | | 22d. LOCATION (City, town, or county) FALLS CHURCH, VA. | |
| (State) | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14 13 ST NW | | ADDRESS | |
| | | 24a. REC'D BY REGISTRAR DATE FEB 24 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2267

CERTIFICATE OF DEATH

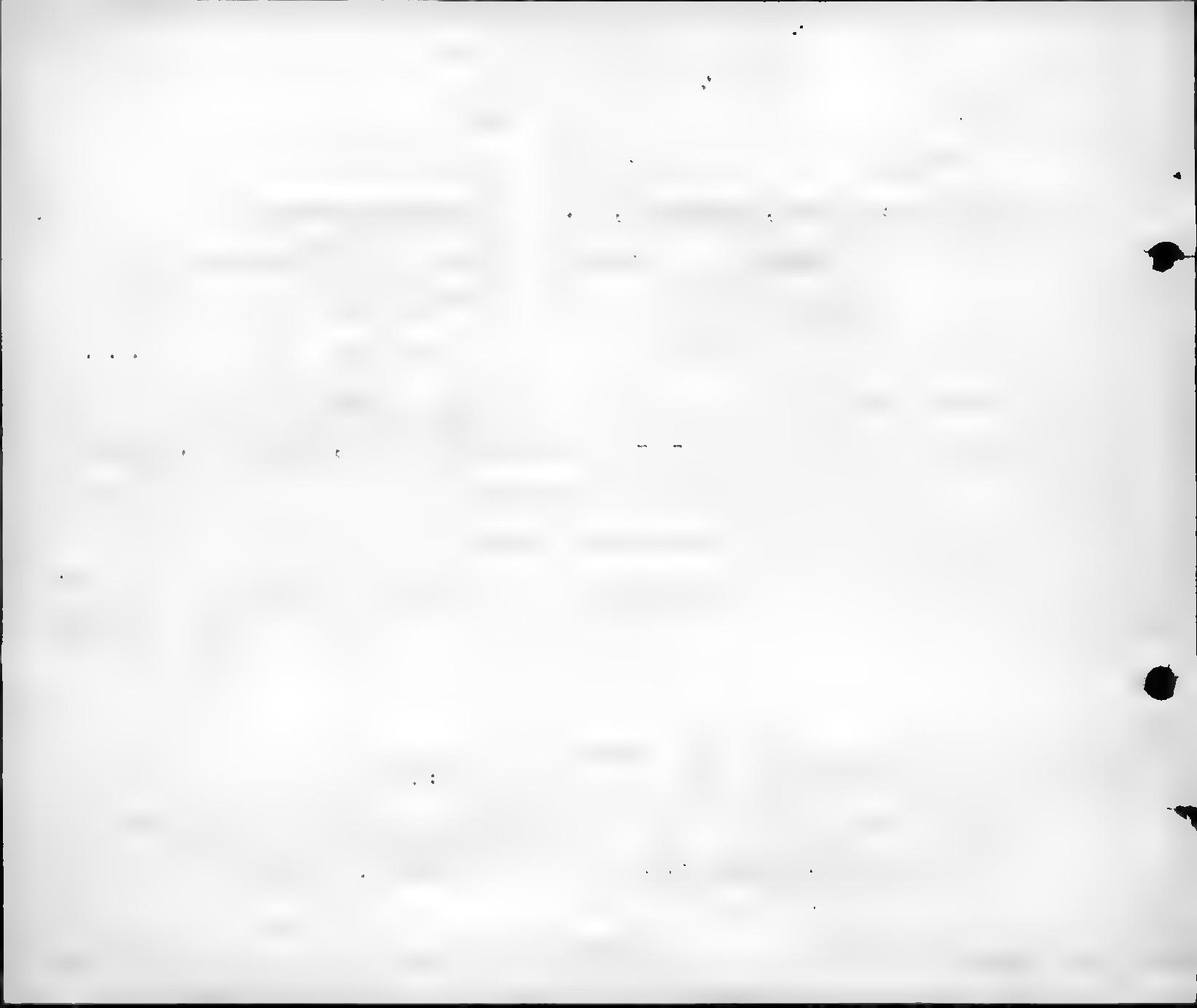
Reg. Dist. No.

02235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|---|--|---|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE New York | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 57 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 505 West 161st Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Harry Aristides Ramirez | | First | Middle | Last | 4. DATE OF DEATH February | Month | Day Year 16 19 60 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH April 8, 1933 | 9. AGE (In years last birthday) 26 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days Hours Min |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Puerto Rico | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Tomas Ramirez | | 14. MOTHER'S MAIDEN NAME Theresa Chapriel | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 126-24-1076 | | INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 401.1 | | Myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | Candida parapsilosis | | | | | |
| DUE TO (c) | | Endocarditis - aortic valve | | 11 months | | | |
| DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from December 21, 1959 , to February 16 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 6:30 PM , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | | DATE SIGNED February 17, 1960 | |
| ACTUAL SIGNATURE Howard M. Kravetz | | M.D. | | The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) HOWARD M. KRAVETZ, M.D. | | | | | | | |
| 22a. BURIAL, CREMATON REMOVAL (Specify) New York | | 22b. DATE THEREOF 1/18/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM 1400 Chapin St NW Washington, D.C. | | 22d. LOCATION (City, town, or county) New York, N.Y. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamberlain | | ADDRESS 1400 Chapin St NW Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE FEB 19 '60 | | 24b. REGISTRAR'S SIGNATURE Carla L. Thomas | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2268

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

4 yr

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2620 Blue Ridge Ave

3. NAME OF
DECEASED
(Type or print)

Dorsey Lee

First

Middle

4. SEX

5. COLOR OF FACE

Male white

6. MARRIED NEVER MARRIED

WIDOWED DIVORCED

7. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOSEPH

14. MOTHER'S MAIDEN NAME

Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

NO

16. SOCIAL SECURITY NO.

213-40-8022

17. INFORMANT

Cornelia Reynolds (wife)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO

(c)

CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

sudden

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

FRANK J. Broschart

M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22e. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 2/23/60

22b. DATE THEREOF

IVY HILL CEMETERY

22c. NAME OF CEMETERY OR CREMATORIUM

ALEXANDRIA, VIRGINIA

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

WALTER E. PIMPUREY, INC.

Raymond A. Ziska

ADDRESS

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

FEB 23 '60

DATE

Arthur S. Lewis

24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2269 CERTIFICATE OF DEATH

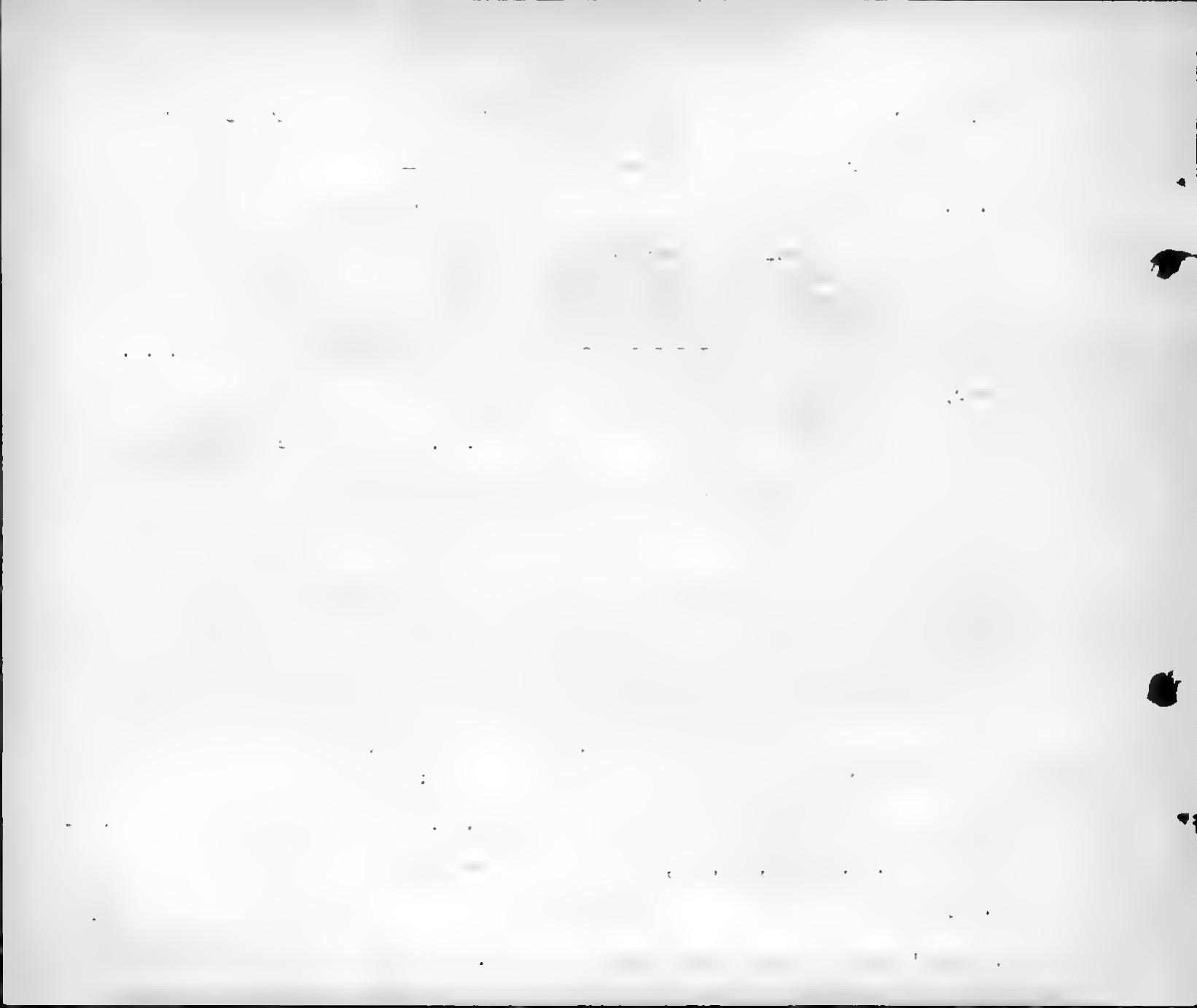
Reg. Dist. No. 215

02257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

| | | | | | | | |
|--|--------------------------------------|---|------------------------------------|---|--|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE Maryland | | b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | d. STREET ADDRESS 4411 Beachwood Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Annie | Middle Hartenstine | Last RHOADS | 4. DATE OF DEATH | Month February | Day 10 | Year 1960 |
| S. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-17-76 | 9. AGE (In years last birthday) 83 yrs. | IF UNDER 1 YEAR Months 83 | IF UNDER 24 HRS Hours 83 | Min. 00 |
| 10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry HARTENSTINE | | | | 14. MOTHER'S MAIDEN NAME Hanna FRYER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT (S) Robt. H. Rhoads, same as #2 above | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach with metastasis DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 30, 1960 , to February 10, 1960 , that I last saw the deceased alive on February 10, 1960 , and that death occurred at 10:50A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>J. L. Beeby</i> | | M.D. U. S. Naval Hospital 2-11-60 | | | | | |
| PHYSICIAN'S NAME (Type) J. L. BEEBY, LT, MC, USN | | Bethesda 14, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | | 22b. DATE THEREOF 2-11-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Forest Hills | | 22d. LOCATION (City, town, or county) Reiffton (State) Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Funeral Home, Hyattsville, Md. | | ADDRESS | | 24a. REC'D. BY REGISTRAR FEB 15 1960 | | 24b. REGISTRAR'S SIGNATURE Curry J. Hale | |



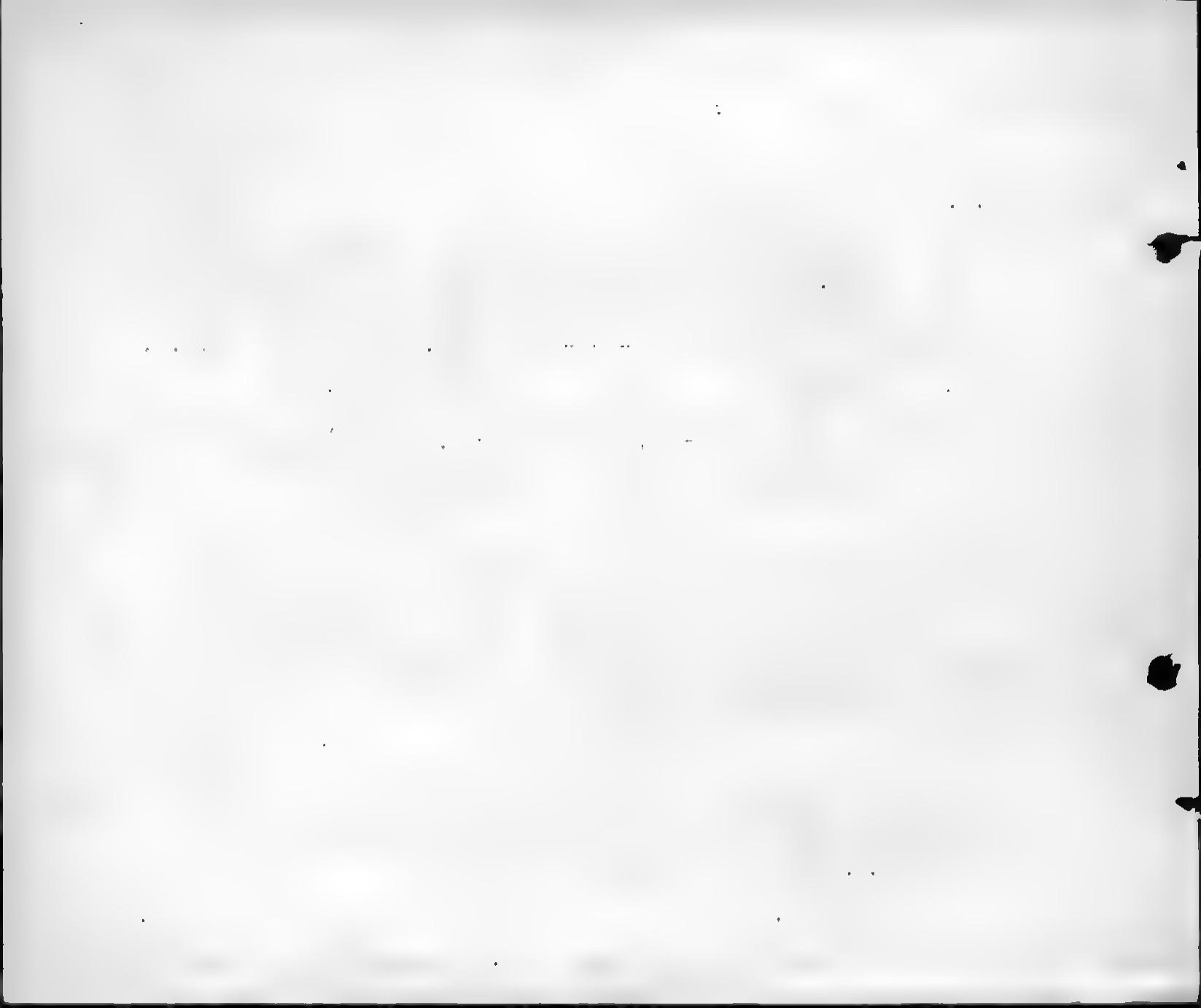
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2270

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | |
|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived—if institution, Residence before admission) a. STATE VIRGINIA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. NAVAL HOSPITAL NNMC | | d. STREET ADDRESS 3135 Martha Custis Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Audrey | First Weston | Middle | Last RICH | 4. DATE OF DEATH February 6, 1960 | Month Year Day Year 1960 19 |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-13-83 | 9. AGE (In years last birthday) 18 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MASS. | |
| 13. FATHER'S NAME George RHINES | | 14. MOTHER'S MAIDEN NAME Effie RHINES | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 021-05-7486 | | INFORMANT Elinor D. RICH(D) Same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Bethesda | (County) Maryland |
| 21. I certify that I attended the deceased from 31 January 1960 to 6 February 1960 , that I last saw the deceased alive on 6 February 1960 , and that death occurred at 2015pm , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Marshall W. Olson M.D. | | | ADDRESS (Street, city or town, state) USNH, NNMC, Bethesda 14 2660 | | |
| PHYSICIAN'S NAME (Type) M. W. OLSON | | DATE SIGNED 2-15-60 | | | |
| 22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial | 22b. DATE THEREOF 11 Feb. 1960 | 22c. NAME OF CEMETERY OR CREMATORIUM Plain Street Cemetery | 22d. LOCATION (City, town, or county) Braintree, Mass. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wheatley Funeral Home Alexandria, Va. | | ADDRESS Wheatley Funeral Home Alexandria, Va. | 24a. REC'D BY REGISTRAR FEB 9 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | DATE |



Item 20 Film 2
3-10-68 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

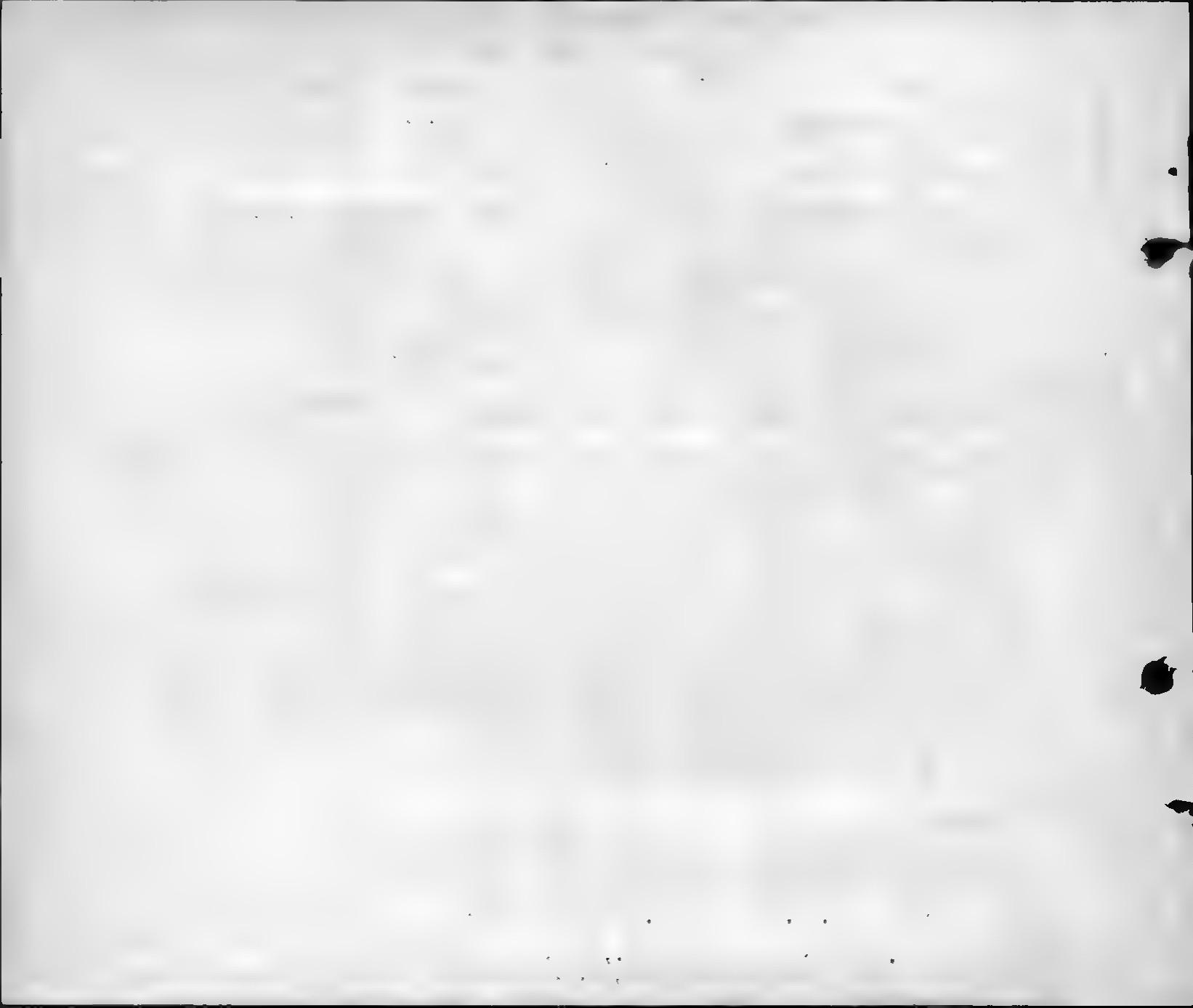
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02239

~~TO DEPUTY MEDICAL EXAMINER:~~ Certificate should be executed within 24 hours after death. If ~~pending~~ "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
~~TO FUNERAL DIRECTOR:~~ Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN Tb D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| f. STREET ADDRESS 1331 Rittenhouse St. N.W. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John | | First Middle John Chesman | 4. DATE OF DEATH February 19 1960 |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18, 1910 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) British W. Indies | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Ricketts | | 14. MOTHER'S MAIDEN NAME Lillian Jeffries | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT Estelle Gonzales (Neife) (As above) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 936.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO Aspiration of Gastric Contents Sudden INTERVAL BETWEEN ONSET AND DEATH Media' | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Was driving his car & stopped to repair his tire chains when he suddenly collapsed | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:20 p.m. 2-19 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | |
| 20f. (City or town) Bethesda | | (County) Montg. | |
| (State) Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Hand J. Bierhart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) FRANK J. Bloschawt | | 2-19-60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2.24.60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire | | ADDRESS 1820 9th St., N.W. Washington, D.C. | |
| | | 24a. REC'D BY REGISTRAR DATE FEB 23 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE C. J. S. K. | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02240

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb
101 daysd. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Poolestown

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
JohnMiddle
LawrenceLast
RIHELDAFFER4. DATE
OF
DEATHMonth
FebruaryDay
6
Year
1960

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9-24-89

9. AGE (In years
last birthday)70
yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

12. CITIZEN OF WHAT COUNTRY?

USA

10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy

11. BIRTHPLACE (State or foreign country)

West Virginia

13. FATHER'S NAME

John C. RIHELDAFFER

14. MOTHER'S MAIDEN NAME

Laura HARDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

Yes

(If yes, give war or dates of service)

WWI - WWII

16. SOCIAL SECURITY NO.

INFORMANT

Address

(W) Evelyn D. Riheldaffer, same as #2 above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

162.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.(b)
DUE TO
(c)INTERVAL BETWEEN
ONSET AND DEATH

7 mo

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

Hypertensive cardiovascular disease

| 20c. TIME OF INJURY | Month, Day, Year | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|------------------------|------------------|---|--|---------------------|----------|---------|
| Hour a. m. p. m. | Month 19 | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | |

21. I certify that I attended the deceased from October 28, 1959, to February 6, 1960, that I last saw the deceased alive on February 6, 1960, and that death occurred at 8:15P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE*F. J. Linehan*

M.D. U. S. Naval Hospital

2-7-60

PHYSICIAN'S
NAME (Type)

F. J. LINEHAN, JR., LCDR, MC, USN Bethesda 14, Maryland

22a. BUR. AL. CREMAT. ON.

REMOVAL (Specify)

Cremation

22b. DATE THEREOF

2-9-60

22c. NAME OF CEMETERY OR CREMATORI

Cedar Hill Crematory

22d. LOCATION (City, town, or county)

Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

R. A. Pumphrey

Funeral Home, Bethesda, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE FEB 9 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

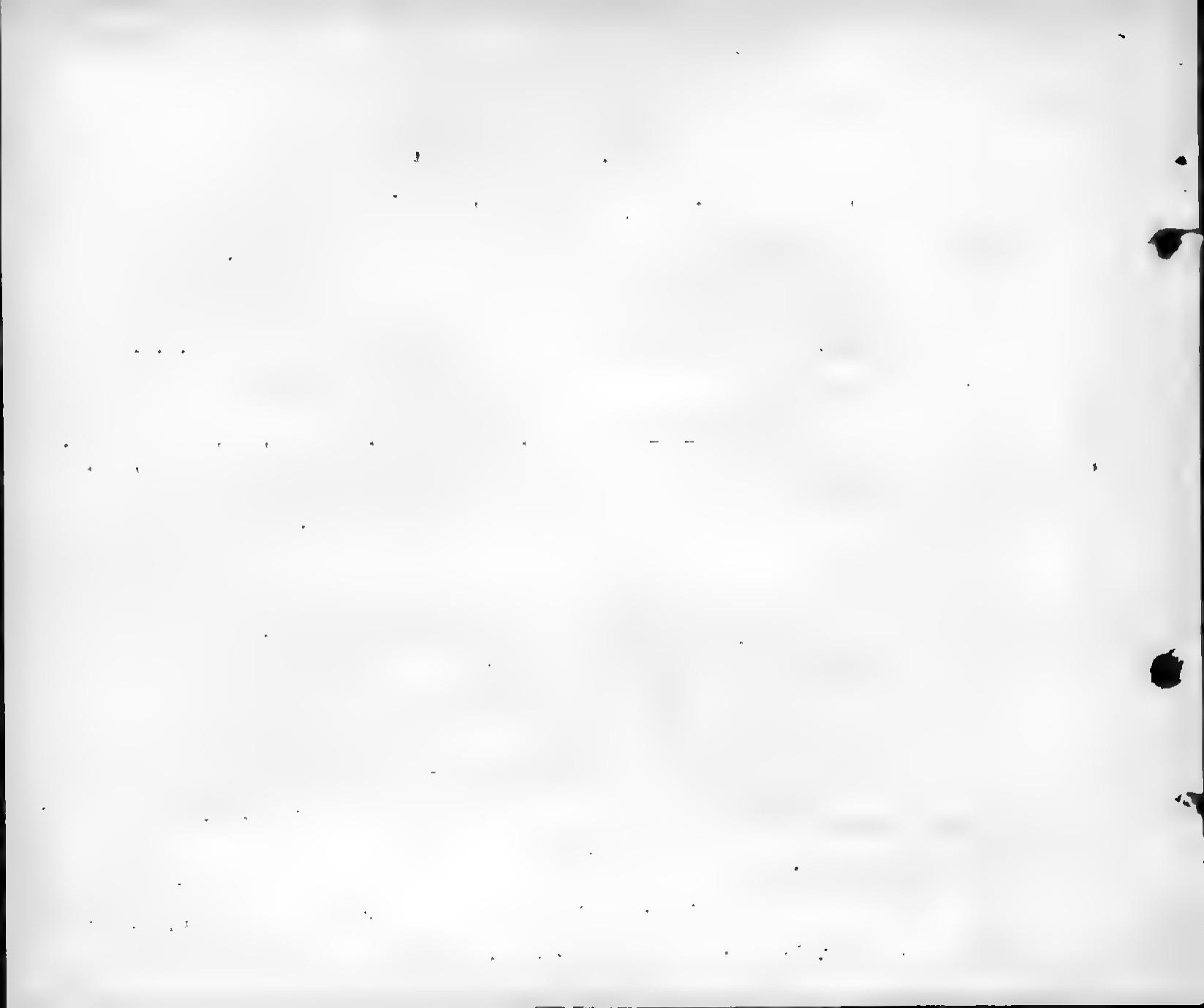
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2125 CERTIFICATE OF DEATH

02241

Reg. Dist. No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|--|---|---|--|---|---------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 6 yrs. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,715 Flack St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE | First GRANT | Middle ROBERTS | 4. DATE OF DEATH FEB. Month Day Year 14 19 60 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/27/04 | | | |
| 9. AGE (In years last birthday) 55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dance Instructor | 11. KIND OF BUSINESS OR INDUSTRY Self-employed | 12. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | | |
| 13. CITIZEN OF WHAT COUNTRY? U.S.A. | 14. MOTHER'S MAIDEN NAME SULLIVAN | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | 16. SOCIAL SECURITY NO. 172-24-2415 | 17. INFORMANT Mrs. Catherine W. Roberts, 12,715 Flack St. | 18. ADDRESS | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | |
| Coronary Arteriosclerosis 5 years Acute Myocardial Infarction 1 day Silver Spring, MD <small>INTERVAL BETWEEN ONSET AND DEATH</small> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASSE CONDITION GIVEN IN PART I(a) Essential Hypertension | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter cause of injury in Part I or Part II of item 1b.) | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 4 | (County) | (State) |
| 21. I certify that I attended the deceased from Feb 1 , 1958 to Feb 14 , 1960 that I last saw the deceased alive on Feb 14 , 1960, and that death occurred at 5 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | DATE SIGNED | |
| ACTUAL SIGNATURE <i>John J. Curry, M.D.</i> | | 106-20 Georgia Ave 21140 Silver Spring, MD | | | | |
| PHYSICIAN'S NAME (Type) JOHN J. CURRY | | 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 2/17/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC. <i>Reynolda O'Ziska</i> | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR FEB 16 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02242

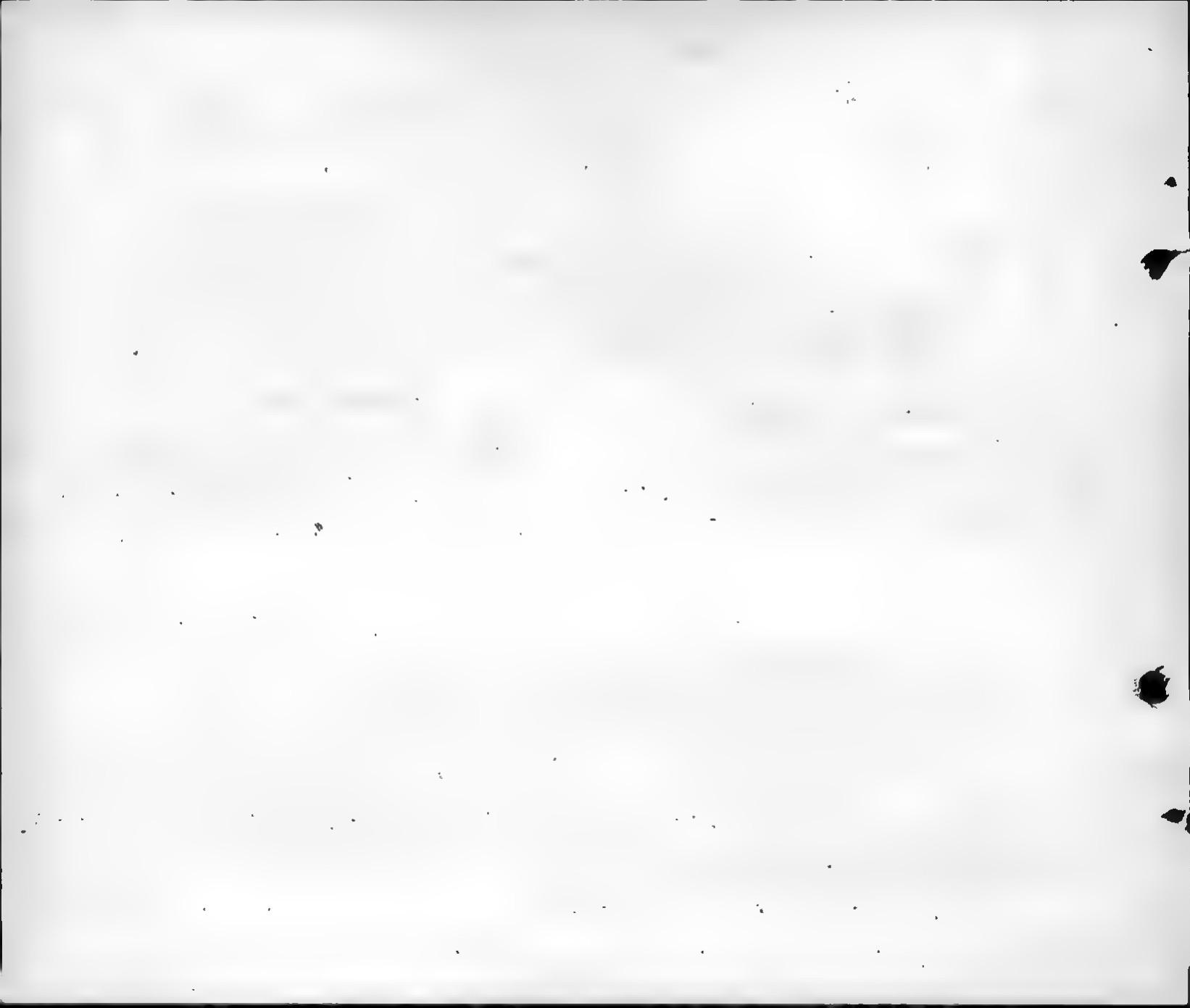
2273 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|--|---|----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY M ontgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 36 Hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | d. STREET ADDRESS 12914 Georgia Ave | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Barbara | Middle Ellen | Last Robinson | 4. DATE OF DEATH Feb. 5 1960 | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B DATE OF BIRTH 4/13/77 | 9. AGE (in years last birthday) 82 yrs. | IF UNDER 1 YEAR Months 82 | IF UNDER 24 HRS. Days hrs. | Hours min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FULL-TIME HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) Jackson, Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN Henry Strope | | 14. MOTHER'S MAIDEN NAME CATHERINE XXXXX Fox | | Address | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No | | 16. SOCIAL SECURITY NO. none | | INFORMANT Maurice Robinson (Husband) Same as Above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis - cerebral artery disease (b) DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 36 hr. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON G VEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Diabetes mellitus YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Death occurred at home | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) COLUMBUS, OHIO | | (County) (State) | |
| 21. I certify that I attended the deceased from 2-3-60 to 2-5-60 , that I last saw the deceased alive on 2-5-60 , and that death occurred at 44 M. from the causes and on the date stated above ADDRESS (Street, city or town, state) P. P. Andrews M.D. 420 Massachusetts Street, Columbus, Ohio | | | | | | | |
| DATE SIGNED P. P. Andrews M.D. 420 Massachusetts Street, Columbus, Ohio | | | | | | | |
| ACTUAL SIGNATURE P. P. Andrews M.D. 420 Massachusetts Street, Columbus, Ohio | | PHYSICIAN'S NAME (Type) Peter P. Andrews | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 2/8/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM UNION CEMETERY | | 22d. LOCATION (City, town, or county) COLUMBUS, OHIO | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Reck | | ADDRESS WARNER E. PIMPHREY, INC. SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR FEB 8 '60 | | 24b. REGISTRAR'S SIGNATURE Carling S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2152

CERTIFICATE OF DEATH

Reg. Dist. No.

02243

| | | | | | |
|--|--|---|--|---|------------------|
| 1. PLACE OF DEATH a. COUNTY | | MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | TAKOMA PARK | | a. STATE | Md. |
| c. LENGTH OF STAY IN 1b | | | | b. COUNTY | MONTG. |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | WASHINGTON SANITARIUM | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 5. STREET ADDRESS | |
| 6. SEX | | First | Middle | Last | 4. DATE OF DEATH |
| F | | W | MILDRED JEANNETTE | ROSE | FEB 14 1960 |
| 7. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| W | | 5-30-1901 | | 9. AGE (In years last birthday) yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | OWN HOME. | | INDIANA | |
| 12. CITIZEN OF WHAT COUNTRY | | | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| HURIE R. LONTZ | | EFFIE FENIMORE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | metastatic Carcinoma | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. | | Abdominal Viscera secondary to | | | |
| DUE TO (b) | | Primary Carcinoma of Colon | | | |
| (c) | | 3 1/2 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Diabetes Mellitus | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 19 | | | | | |
| 21. I certify that I attended the deceased from Jan 1, 1957, to Feb 14, 1960, that I last saw the deceased alive on Feb 13, 1960, and that death occurred at 1327 M. from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE M.D. 10620 Georgia Ave Feb 14 1960 | | | | | |
| PHYSICIAN'S NAME (Type) George L Ball Silver Spring Md | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIUM | |
| Burial Feb 1960 | | 1960 | | Arlington National Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | |
| Robert Hall | | WASH DC | | DATE FEB 17 '60 | |
| 25. CARDBOARD SIGN | | | | 24b. REGISTRAR'S SIGNATURE | |
| George L Ball | | Silver Spring Md | | A. J. S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN
may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12244

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2274

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| Montgomery Maryland | | a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | b. COUNTY Montgomery | |
| c. LENGTH OF STAY IN 18 DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban | | d. STREET ADDRESS 9705 De Paul Drive | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Christopher A. Ross | | 4. DATE OF DEATH Feb 19 1960 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 1-11-1960 | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) 19 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 10c. BIRTHPLACE (State or foreign country) Md | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William David | | 14. MOTHER'S MAIDEN NAME Ross Patricia June Bagley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Sister-in-Law, friend | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital heart failure sudden | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subacute steeritis | | | |
| DUE TO (c) Congenital heart disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Bhosehant</i> | | DATE SIGNED 2-20-1960 | |
| EXAMINER'S NAME (Type) <i>Frank J. Bhosehant</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 2/23/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| | | 24a. RECD BY REGISTRAR FEB 24 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |



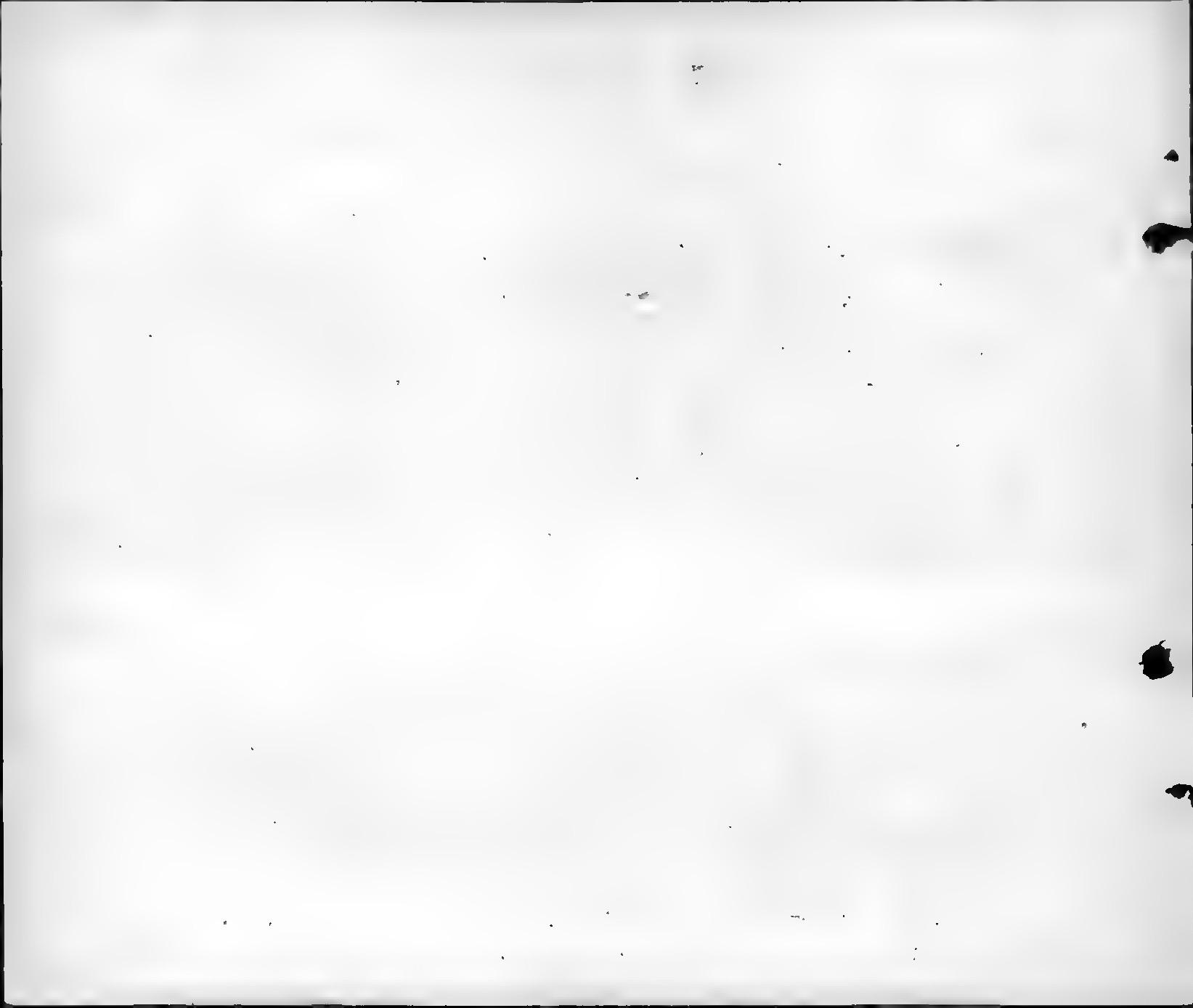
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02245

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>District of Columbia</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>16 da.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium Hospital</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Fannie Otto Rupert</i> | | d. STREET ADDRESS <i>415 19th St. N.W.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <i>Fe</i> | 6. COLOR OR RACE <i>Wh</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3 - 8 - 70</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Actor - War Dept.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>4.5</i> | |
| 13. FATHER'S NAME <i>Rupert, Wm.</i> | | 14. MOTHER'S MAIDEN NAME <i>Martin, Elizabeth</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592x</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c) | | DUE TO <i>Chronic Glomerular Nephritis</i> DUE TO <i>Mural Thrombiq Aorta</i> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> <i>3 wk.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>2 - 9 - 1960</i> , to <i>2 - 23 - 1960</i> that I last saw the deceased alive on <i>2 - 23 - 1960</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED <i>Robert A. Hare, M.D. 809 Davis Ave., T. Park, Md. 2/23/60</i> | |
| ACTUAL SIGNATURE <i>Robert A. Hare</i> | | PHYSICIAN'S NAME (Type) <i>Robert A. Hare, M.D.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>2-26-1960</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Crematory</i> | | 22d. LOCATION (City, town, or county) <i>Suitland, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Gavleisides Jr.</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 25 '60</i> | |
| ADDRESS <i>1756 Pa. Ave. N.W.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Clinton S. Kuhn</i> | |



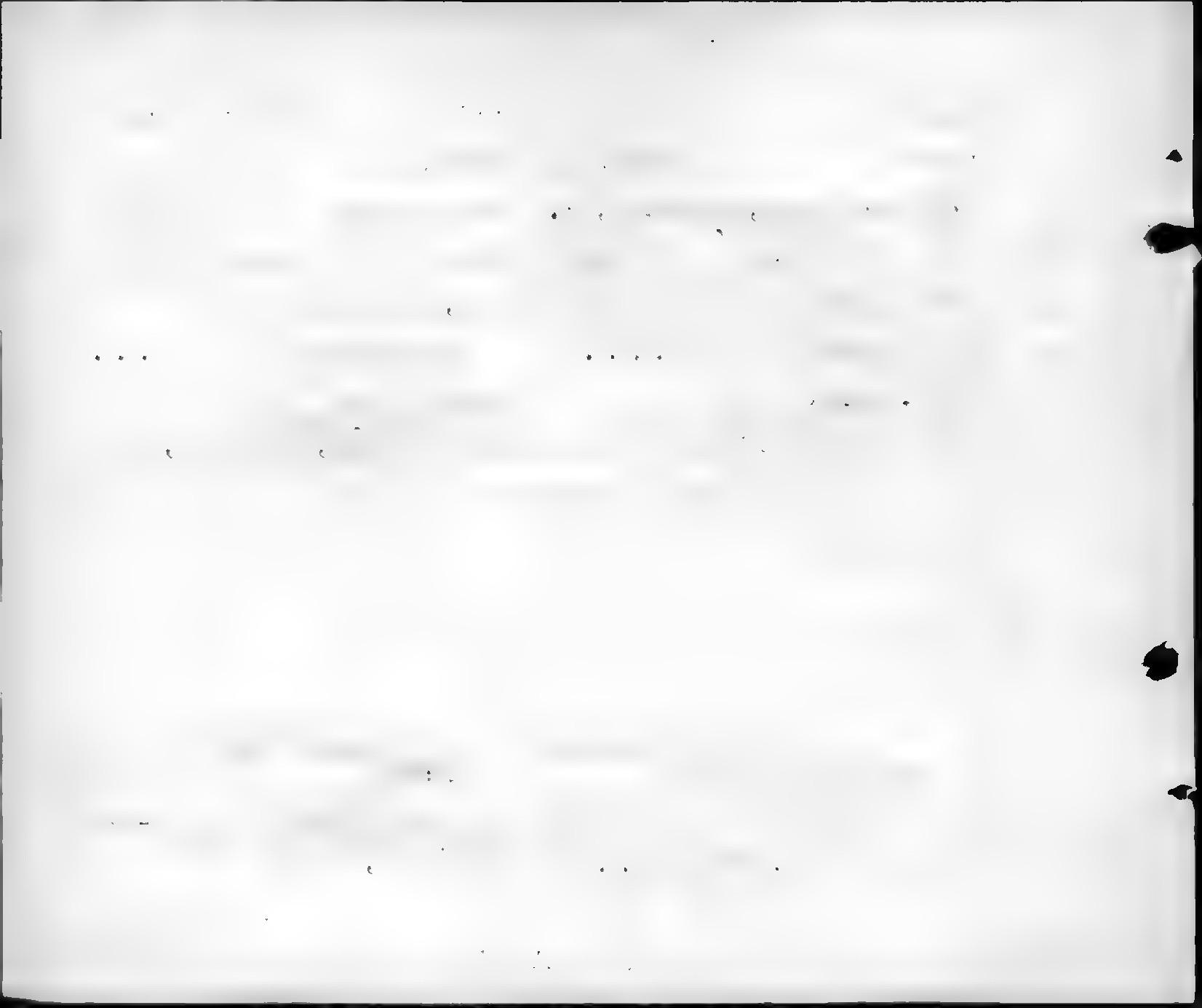
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2275 CERTIFICATE OF DEATH

Reg. Dist. No.

02246

| | | | | | | | | |
|--|--|---|---|---|--|--|--|---|
| 1 | | TO HOSPITAL OR ATTENDING PHYSICIAN may be retained by the hospital or attending physician. | | TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. | | | | |
| | | 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | | | |
| | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 88 days | | | | |
| 2 | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | | | |
| | | | | b. COUNTY Prince Georges | | | | |
| | | f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover | | g. STREET ADDRESS 100 3rd Street | | | | |
| | | h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. | | First Clyde | Middle (None) | Last Russell | 4. DATE OF DEATH February 19 | Month 19 | Day 19 | Year 60 |
| 5. SEX | | 6. COLOR OR RACE Male | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH July 14, 1914 | 9. AGE (In years last birthday) 45 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Hours 0 | 12. IF UNDER 24 HRS Min. 0 |
| 10a | | 10b | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John M. Russell | | 14. MOTHER'S MAIDEN NAME Hattie Wiseman | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (Active duty) Unascertainable | | 16. SOCIAL SECURITY NO INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | |
| 18. CAUSE OF DEATH [Enter on one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Bronchial Obstruction | | 19. INTERVAL BETWEEN ONSET AND DEATH 1 Hour | | | | |
| 17A.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | (b) DUE TO Malignant Melanoma | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from November 23, 1959 , to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred on 10:00 am from the causes and on the date stated above. ACTUAL SIGNATURE Charles E. Mengel, M.D. PHYSICIAN'S NAME (Type) CHARLES E. MENGEGL, M.D. | | ADDRESS (Street, city or town, state) | | DATE SIGNED 2-19-60 | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/23/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem. | | 22d. LOCATION (City, town or county) (State) Arlington, Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. J. Rinaldi | | ADDRESS Rinaldi Funeral Home, Inc. 816 H St., NE, Wash., DC | | 24a. REC'D BY REGISTRAR DATE FEB 23 '60 | | 24b. REGISTRAR'S SIGNATURE L. Charles E. Mengel | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2276 CERTIFICATE OF DEATH

Reg. Dist. No.

02247

| | | | |
|---|--|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | b. COUNTY Montgomery |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's—Rural | c. LENGTH OF STAY IN lb 25 yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boyd's-----Rural | d. STREET ADDRESS |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | |

| | | | | | | | |
|--|----------------------|-------------------------|-----------------------|--|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First Osie | Middle Bertha | Last Savage | 4. DATE OF DEATH Feb. 1 1960 | Month | Day | Year |
|--|----------------------|-------------------------|-----------------------|--|-------|-----|------|

| | | | | | | |
|-------------------------|----------------------------------|---|---|---|---------------------------|-------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH Sept 13-1891 | 9. AGE (In years last birthday) 68 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days |
|-------------------------|----------------------------------|---|---|---|---------------------------|-------------------------|

| | | | |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S |
|---|--|--|--|

| | |
|---|--|
| 13. FATHER'S NAME Charles Poole | 14. MOTHER'S MAIDEN NAME Rachel V. House |
|---|--|

| | | | |
|---|-------------------------|-----------|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. | INFORMANT | Address |
|---|-------------------------|-----------|---------|

Mr Leroy Savage, Boyd's, R.F.D., Maryland

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>Aspiration pneumonia</i> | | 4 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Cerebral Hemorrhage</i> | | 6 days |
| (c) <i>Cerebral arteriosclerosis</i> | | 2 yrs. |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

| | | |
|--|--|---|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) |

| | | | |
|--|--|---------------------------------------|-------------|
| 21. I certify that I attended the deceased from Dec. 3, 1959, to Feb 1, 1960 that I last saw the deceased alive on Feb. 1, 1960 , and that death occurred at 5:00 A.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) | DATE SIGNED |
|--|--|---------------------------------------|-------------|

| | | | |
|--|------|-------------------------------|--|
| ACTUAL SIGNATURE <i>Vernon E. Martens</i> | M.D. | <i>Residence, Md Feb 2-60</i> | |
|--|------|-------------------------------|--|

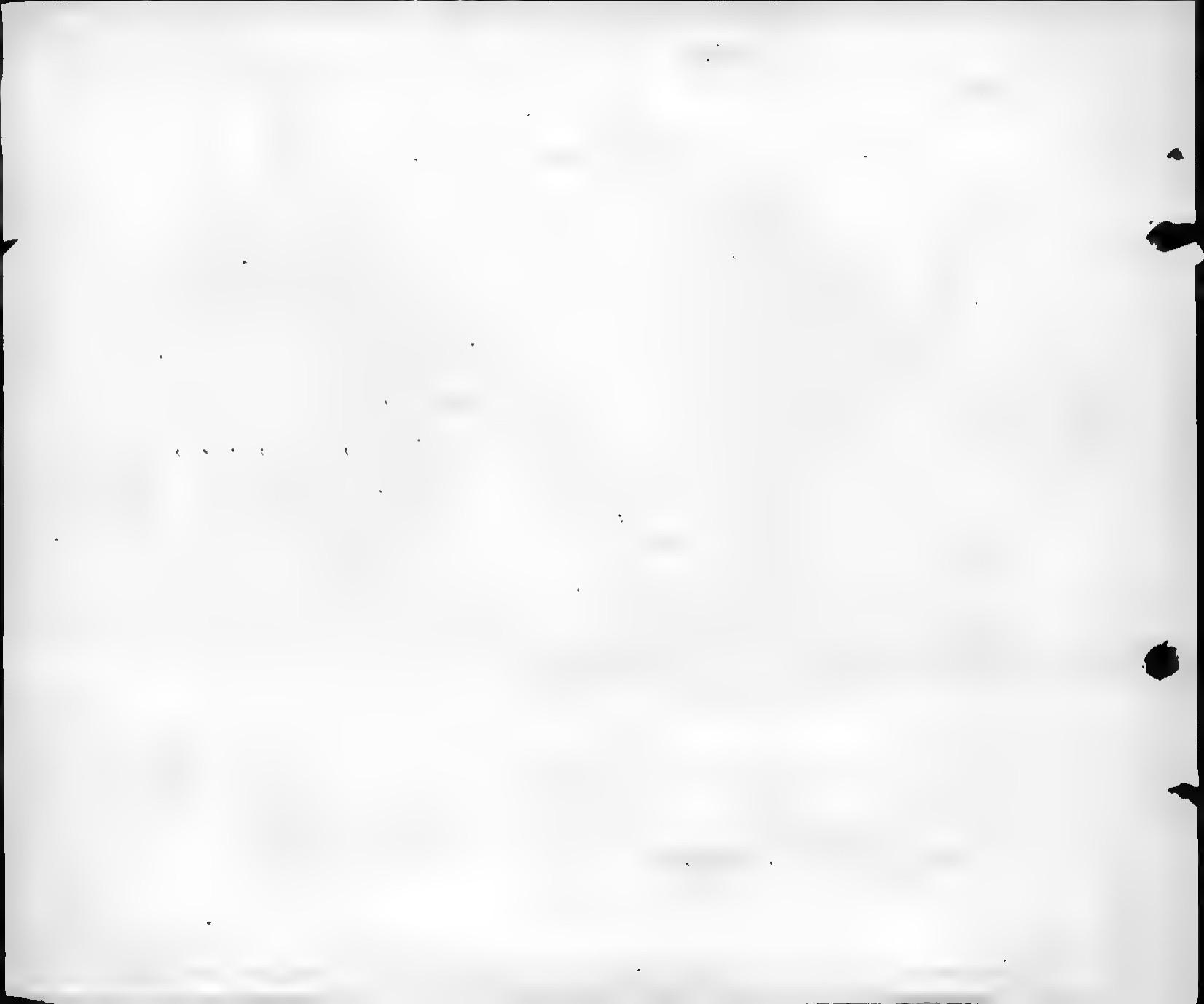
| | | | |
|---|--|--|--|
| PHYSICIAN'S NAME (Type) Vernon E. Martens | | | |
|---|--|--|--|

| | | | |
|--|------------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/3/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Monocacy | 22d. LOCATION (City, town, or county) Beallsville, Maryland |
|--|------------------------------------|---|---|

| | | | |
|---|---------|--|--|
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hillen, Baltimore, MD</i> | ADDRESS | 24a. REC'D BY REGISTRAR DATE FEB 4 1960 | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i> |
|---|---------|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2154 CERTIFICATE OF DEATH

Reg. Dist. No.

02248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------------|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Prince George</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>5 min-</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> | | d. STREET ADDRESS <i>4865-66th Ave</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>ANNA Josephine Schana</i> | | First | Middle | Last | 4. DATE OF DEATH Month Feb Day 29 Year 60 Feb 29 1960 | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/13/80</i> | 9. AGE (In years last birthday) <i>79 yrs</i> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housenurse</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Austria</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | |
| 13. FATHER'S NAME <i>? Duchon</i> | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>— — — — —</i> | | INFORMANT <i>Son-Jennings w Schana</i> | | Address <i>4865-66th Ave Hyattsville Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Cerebral hemorrhage</i> (c) DUE TO <i>Cerebral arteriosclerosis</i> (same) INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Medical anticoagulation (Dicumarol)</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <i>Oct 1959</i> to <i>2/29/60</i> , that I last saw the deceased alive on <i>Feb. 6 1960</i> , and that death occurred on <i>2/29 AM</i> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <i>Donald Nelson M.D. 10620 Georgia Ave Silver Spring, Md.</i> | | | | | | | |
| DATE SIGNED <i>2/29/60</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Donald Nelson</i> | | PHYSICIAN'S NAME (Type) <i>DONALD NELSON</i> | | | | | |
| 22a. Cremation REMOVAL (Specify) <i>Bernards 3-4-60</i> | | 22b. DATE THEREOF <i>3-4-60</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i> | | 22d. LOCATION (City, town, or county) <i>Silver Spring</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i> | | ADDRESS <i>4812 Georgia Ave NW</i> | | 24a. REG'D BY REGISTRAR <i>MARY J. BOYD</i> | | 24b. REGISTRAR'S SIGNATURE <i>Donald Nelson</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN One law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,5 film G256 2-1-60 et
 227? CERTIFICATE OF DEATH

Reg. Dist. No. 215

12249

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 2½ hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL NNMC | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| 3. NAME OF DECEASED (Type or print) Grover Cleveland | | First Grover | Middle Cleveland |
| | | Last SCHNELL | 4. DATE OF DEATH February 7 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-1-85 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Buchanan PADGETT | | 14. MOTHER'S MAIDEN NAME Arabelle LOCKARD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. INFORMANT Mildred SLAUGHTER (D) same as #2 | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6 February 1960 to 7 February 1960 , that I last saw the deceased alive on 7 February 1960 , and that death occurred at 0115 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Mark H. Olson, Jr. | | ADDRESS (Street, city or town, state) M.D. 414 14th and 16th Streets, Washington, D.C. DATE SIGNED 2-11-60 | |
| PHYSICIAN'S NAME (Type) M. W. OLSON LCDR MC USN | | 22b. DATE THEREOF 2-11-60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National | | 22d. LOCATION (City, town, or county) Arlington, Va. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES | | ADDRESS 2901 14th St. W.D.C. | |
| | | 24a. REC'D BY REGISTRAR DATE FEB 9 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline |

Note: Sex and given names verified by records of N.S.Naval Hosp.

et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 1218G270 2-23-60 et

2126

CERTIFICATE OF DEATH

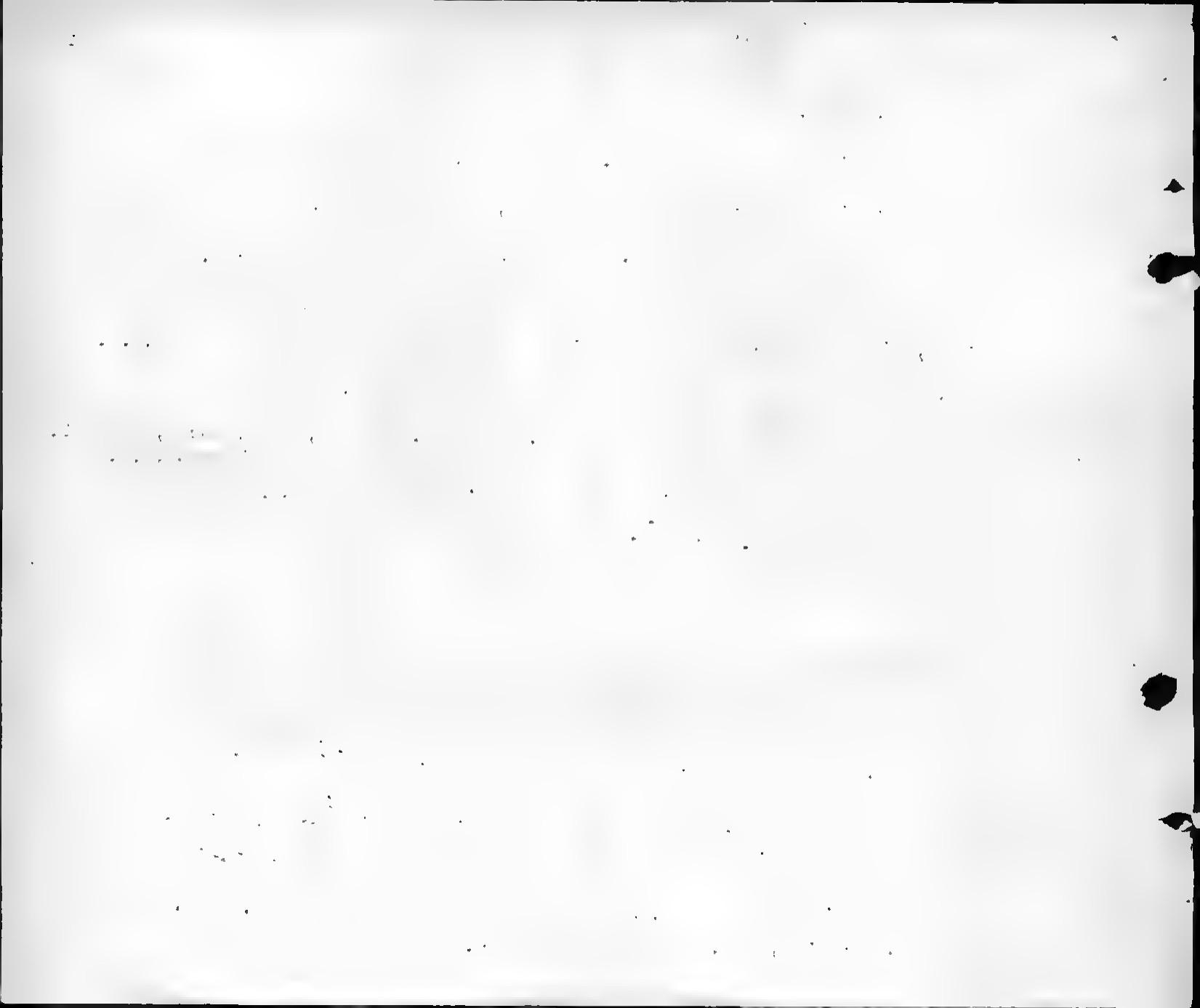
Reg. Dist. No.

(02250)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 3 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| f. STREET ADDRESS 11,403 Monteray Drive | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM G. SCHULER | | First WILLIAM | Middle G. |
| Last SCHULER | | 4. DATE OF DEATH FEB. 16 1960 | Month Day Year |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/1/68 |
| 9. AGE (In years last birthday) 89 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 | 11. IF UNDER 24 HRS Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor, Civilian employee of Marie Corps | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME GODFREY SCHULER | | 14. MOTHER'S MAIDEN NAME MARY unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Elwood W. Schuler, Dodge House, 20 E St. NW Washington D.C. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | |
| DUE TO DUE TO DUE TO | | Congestive Heart Failure | |
| | | Arteriosclerotic Heart Disease | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 10, 1948, to Feb 16, 1960 that I last saw the deceased alive on Feb 16, 1960 and that death occurred at 57 M , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 9500 Colesville Rd Silver Spring Md | |
| ACTUAL SIGNATURE H. B. ORLEANS | | DATE SIGNED 2/18/60 | |
| PHYSICIAN'S NAME (Type) H. B. ORLEANS | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/19/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | 24a. REC'D BY REGISTRAR DATE FEB 18 '60 | |
| ADDRESS SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE Caroline S. Kline | |



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2155

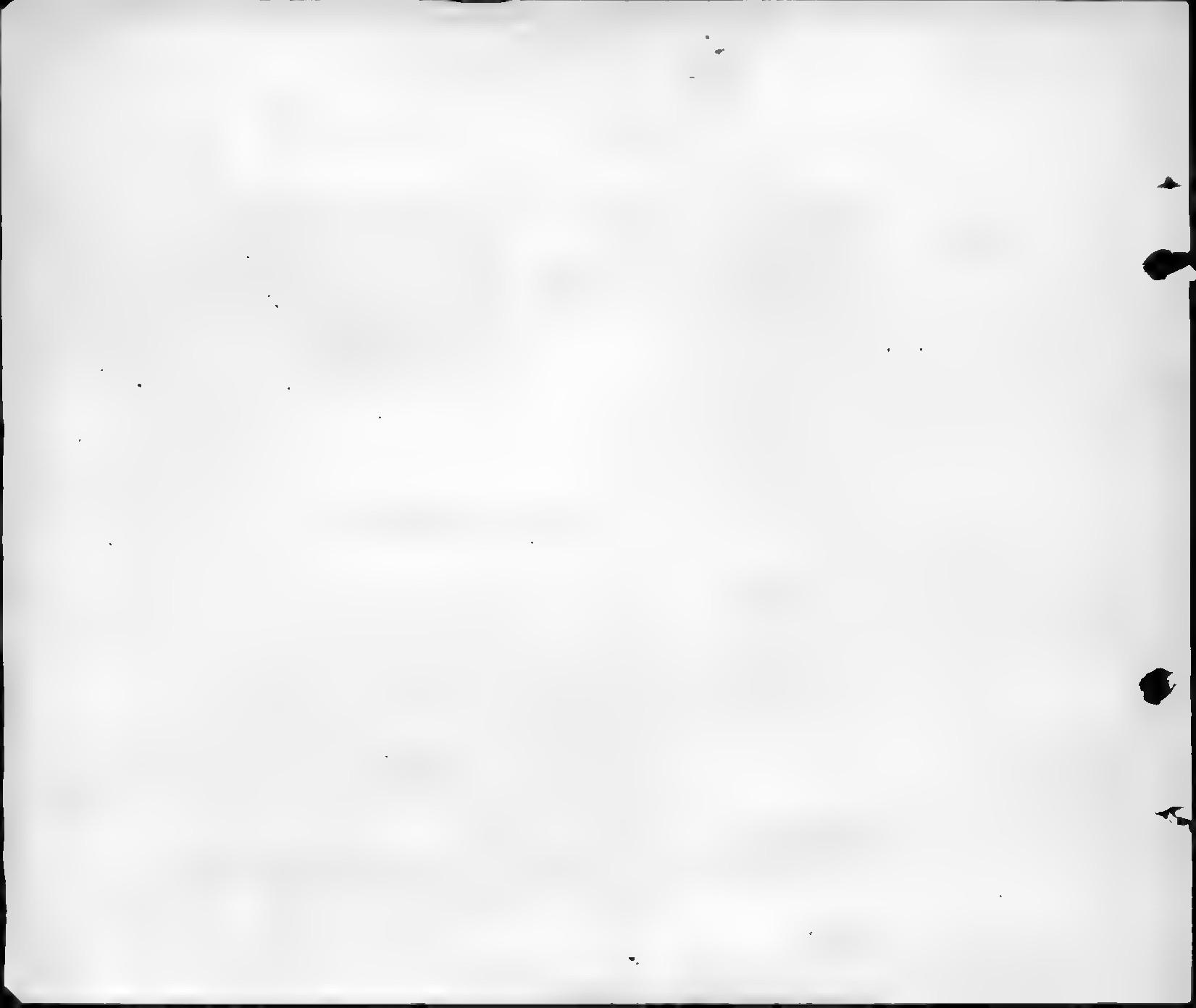
12251

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH o COUNTY <i>Maryland</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <i>Md</i> b. COUNTY <i>Baltimore County</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>at home - 1st fl.</i> | | c. LENGTH OF STAY IN lb <i>10 yrs.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street addr or institution) <i>2001 Carroll Avenue</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Tahoma Park</i> | |
| 3. NAME OF DECEASED (Type or print) <i>James E. Clark</i> | | First <i>James</i> | Middle <i>E</i> |
| 4. DATE OF DEATH <i>Jan 07</i> | | Last <i>Se-07</i> | Month <i>Feb.</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>Oct 18, 1912</i> | | 9. AGE (In years, lost birth day) <i>47 yrs</i> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min |
| 10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Post Office</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Post Office</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Iowa</i> | | 12. CITIZEN OF WHICHCOUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Harry. Clark</i> | | 14. MOTHER'S MAIDEN NAME <i>Emily Marie Wells</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>CLARK H. SEAN 500 12345-6789</i> | |
| 17. INFORMANT <i>Clark H. Sean</i> | | Address <i>1234 Carroll Ave., Baltimore, Maryland 21214</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>Ch. Deg. Myocarditis -</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>seconds</i> | |
| DUE TO (b) <i>Anginal Pain - ai</i> | | DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month Day Year Hour o m p. m. <i>19</i> | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <i>Baltimore, Md. 21214</i> | |
| 21. I certify that (I) (this hospital) attended the deceased from... <i>saw the deceased alive on</i> <i>2/14/60</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above | | 21. I certify that (I) (this hospital) attended the deceased from... <i>saw the deceased alive on</i> <i>2/14/60</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above | |
| 22a. SIGNATURE <i>Howard I. Mouse</i> | | 22b. DATE SIGNED <i>2/18/60</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Howard I. Mouse</i> | | 22d. ADDRESS <i>7030 Carroll Ave., Takoma Park, Maryland 20912</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Feb. 18, 1960</i> | |
| 23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 20912</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Clark</i> | | 25a. ADDRESS <i>254 Carroll Ave., Baltimore, Maryland 21214</i> | |
| 25b. REC'D BY REGISTRAR <i>J. C. L.</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Clark</i> | |
| DATE FEB 23 1960 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 2 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 252

2165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if out'side corporate limits, write RURAL and give nearest town)

Gaithersburg

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

20 Summit Ct.

MARYLAND

c. LENGTH OF STAY IN lb

1½ hrs.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Feb. 27, 1960

19

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

1/16/1898

1898

58 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mack Shifflett

Fannie Shifflet

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mamie A. Shifflet, Rockville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

430.1

DUE TO

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

Feb. 27, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIUM
22d. LOCATION (City, town, or country) (State)

Burial 3-1-60

ParkLawn

Rockville, Md.

(State)

23. FUNERAL DIRECTOR

Ernest C. Gartner. Gaithersburg. Md.

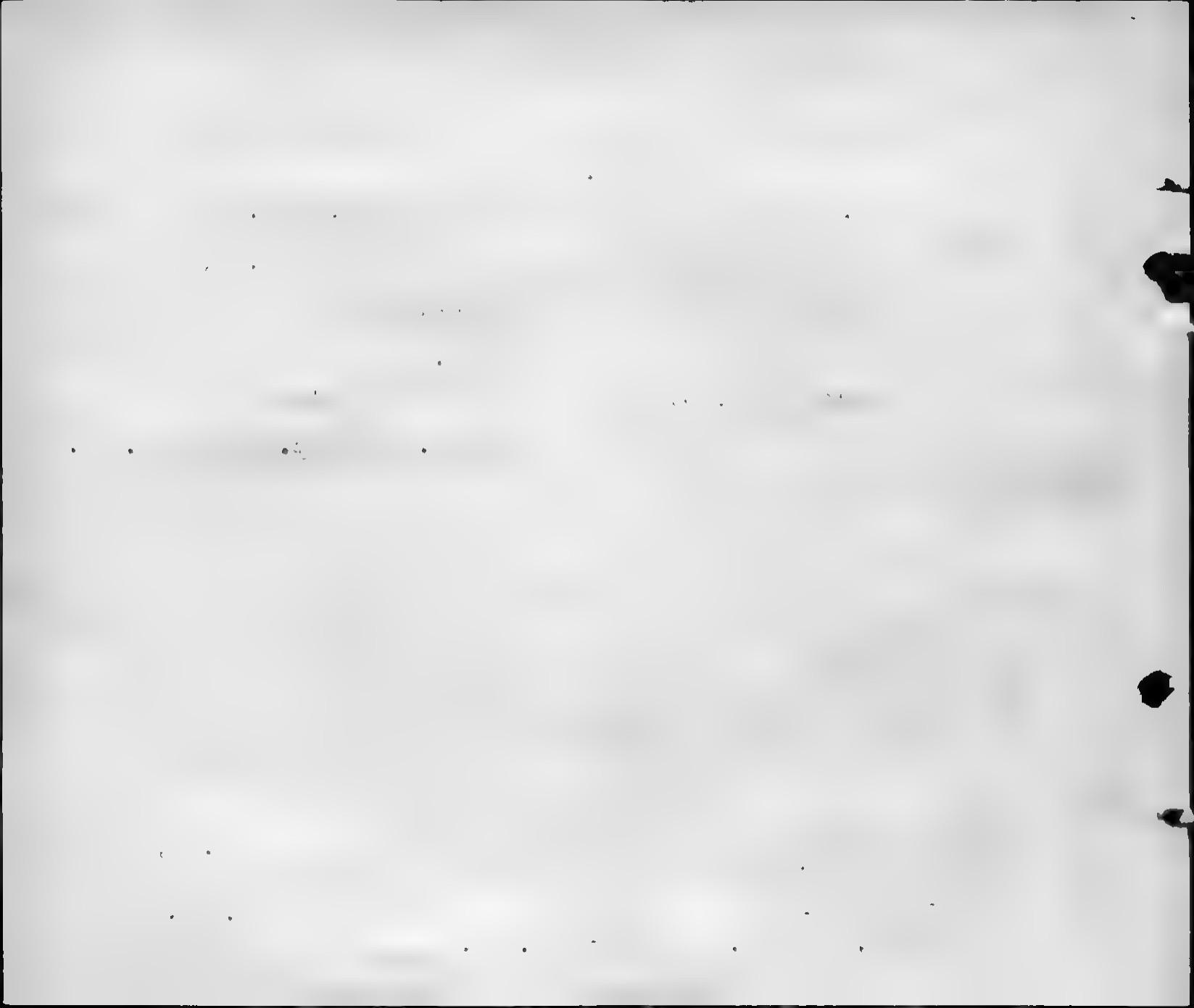
ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAR 1 '60

Arthur S. Kraus



3
1

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112253

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | 2156 Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | D.C. a. Takoma Park | | d. STATE Maryland b. COUNTY Prince Georges |
| c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | Washington Sanitarium Hospital | | d. STREET ADDRESS 9223 Baltimore Blvd. College Park 1670-2 |
| 3. NAME OF DECEASED (Type or print) | First John | Middle Andrew | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 4. DATE OF DEATH | Month 2 | Day 19 | Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-6-1932 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employment of an N.S. You. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Louis E. Sievert | 14. MOTHER'S MAIDEN NAME Christina Gerstner | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Brother-in-Law Address Beltsville Md. David J. Breerwood 4511 Yates Rd. | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH Median | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fracture of skull | | DUE TO (b) Fracture of skull (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in accident | |
| 20c. TIME OF INJURY Hour a.m. 12:30 p.m. Month, Day, Year 2-19-60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Adelphi (County) P.S. (State) Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) FLANK J. BROSCHART | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2-19-60 |
| 22a. BURIAL, CREMATION, REMOVAL (specify) Buffalo | 22b. DATE THEREOF 2/22/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln | 22d. LOCATION (City, town, or county) Colmar Manor, (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Broschart Sons | 4739 Baltimore Ave. Hyattsville, Md. | 24a. REC'D BY REGISTRAR FEB 24 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kinney |

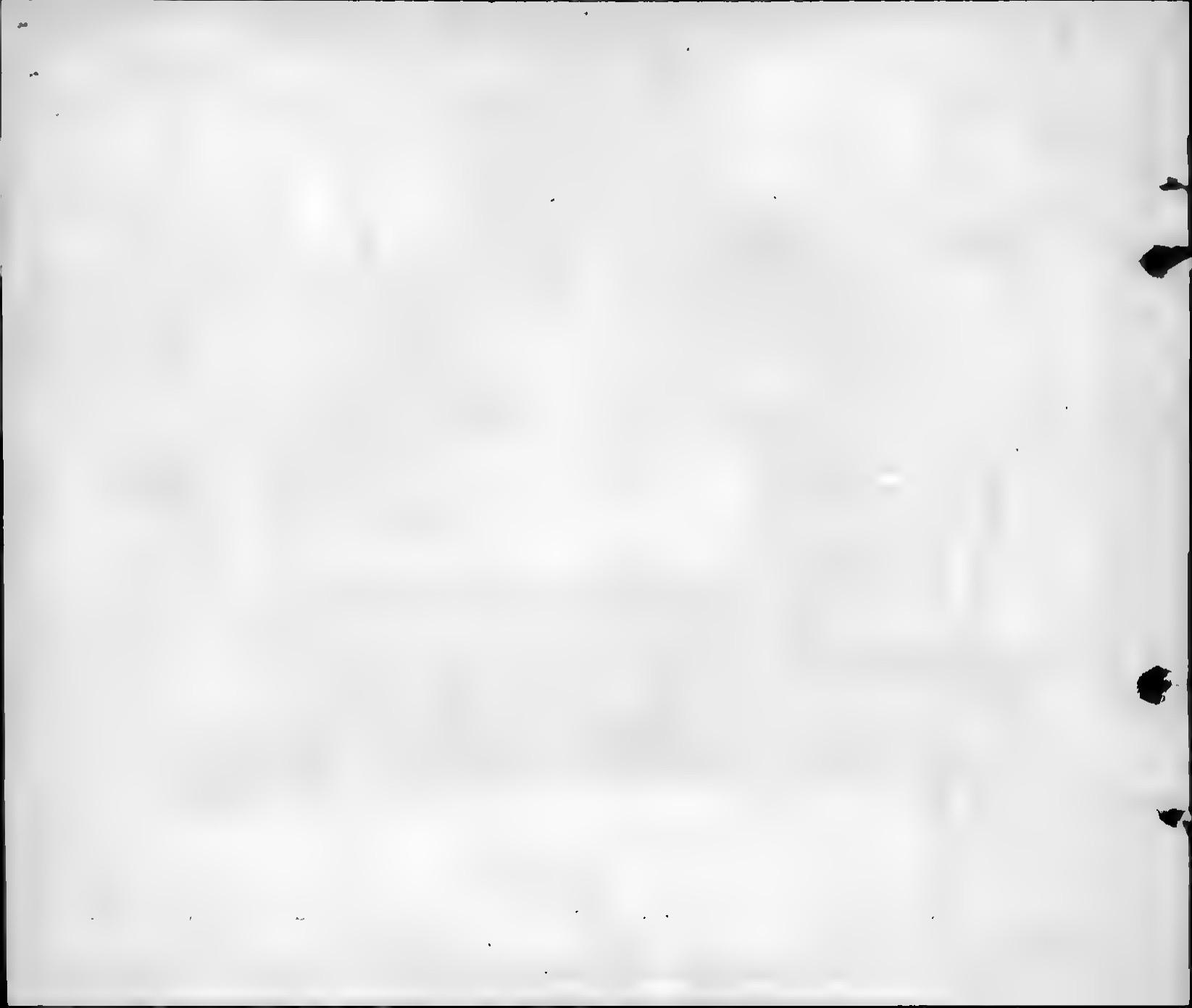


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02254

Reg. Dist. No.

| | | | | | |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | 3157 | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN lb <u>D.C.A.</u> | | d. STATE <u>MARYLAND</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | e. STREET ADDRESS <u>9223 Baltimore Blvd.</u> | | e. COUNTY <u>Prince Georges</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Venita (Vivian) Sievert</u> | | f. DATE OF DEATH <u>2 - 19 1960</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>11-28-25</u> | | 9. AGE (In years from birthday) <u>31 yrs.</u> | | 10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> 11. IF UNDER 24 HRS. <u>Hours</u> <u>Min</u> | |
| 10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector - Stone Straw Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Lynch Kentucky</u> | |
| 13. FATHER'S NAME <u>Stanley Hazalski</u> | | 14. MOTHER'S MAIDEN NAME <u>Jacie</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>10</u> | | 16. SOCIAL SECURITY NO. <u>214-37-9545</u> | | 17. INFORMANT <u>Sister Address Mrs. Ann Breckmead - 4511 Estateside</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Central hemorrhage + lacration</u> DUE TO Conditions. If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) | | <u>sudden</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car involved in accident</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12:20 p.m.</u> <u>2-19</u> <u>1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Baltimore</u> | |
| 20f. (City or town) <u>Adelphi</u> | | (County) <u>P.G.</u> | | (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | DATE SIGNED <u>2-19-60</u> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/22/60</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Ft. Lincoln</u> | |
| 22d. LOCATION (City, town, or county) <u>Colmar Manor</u> | | (State) <u>Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Marchis Sons</u> | | 4739 Baltimore Ave. Hyattsville, Md. | | 24a. REC'D. BY REGISTRAR <u>Arthur S. Klaus</u> FEB 24 '60 DATE | |
| VS. A15MEI SM 9/55 | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2278 CERTIFICATE OF DEATH

Reg. Dist. No.

02255

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| <i>Bethesda, Md.</i> | | <i>Virginia</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b <i>5mo. 20 days.</i> | |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holmes-Bethesda</i> | | d. STREET ADDRESS <i>2109 1/2 St. N.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>John</i> | Middle <i>Elmer</i> | Last <i>Simpson</i> |
| 4. DATE OF DEATH | Month <i>Feb.</i> | Day <i>1</i> | Year <i>1960</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>27 April 1887</i> |
| 9. AGE (In years lost birthday) <i>72 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>9</i> | 11. IF UNDER 24 HRS Days <i>9</i> | 12. Hours <i>9</i> |
| 13. FATHER'S NAME <i>Henry P. Simpson</i> | 14. MOTHER'S MAIDEN NAME <i>Clara J. [unclear]</i> | 15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 16. SOCIAL SECURITY NO <i>Unknown</i> | 17. INFORMANT <i>Walter R. Simpson-Bethesda, Md.-Neighb</i> | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| | | INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify, that I attended the deceased from <i>Jan. 15</i> , 19 <i>66</i> , to <i>Feb. 6</i> , 19 <i>66</i> , that I last saw the deceased alive on <i>Feb. 5</i> , 19 <i>66</i> , and that death occurred at <i>8:15 AM</i> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>1746 1/2 St. N. W.</i> | |
| ACTUAL SIGNATURE <i>MARCEL J. FORET</i> | | DATE SIGNED <i>17 Feb 1966</i> | |
| PHYSICIAN'S NAME (Type) <i>MARCEL J. FORET</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2-8-60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Hollywood Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Richmond, Virginia</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

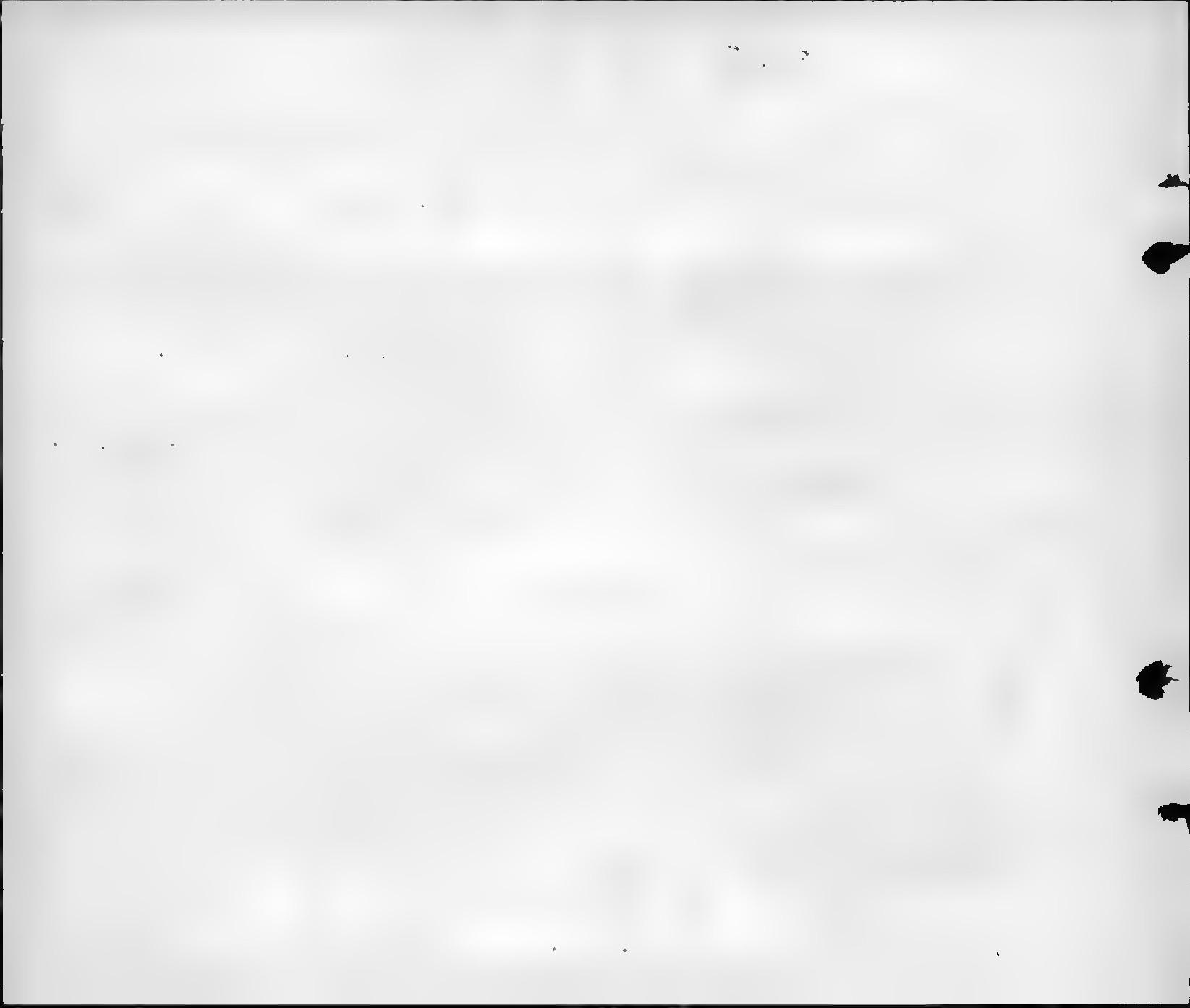
02256

2127

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|---|--|---|---|--|---|---|--------------------------------------|-------------------------------|--------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | d. STREET ADDRESS 8103 Eastern Avenue | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8103 Eastern Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Nettie Kessler | | First Nettie | Middle | Last SIPKIN | 4. DATE OF DEATH February 22, 1960 | Month February | Day 22 | Year 1960 | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 18, 1909 | 9. AGE (In years last birthday) 50 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Harry Schwartz | | | | 14. MOTHER'S MAIDEN NAME Anna Rubin | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT George Sipkin | | Address 8103 Eastern Ave., S.S., Md. | | | |
| No | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CARCINOMA | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST (POST-OP.) | | DUE TO | | | | OVER 6 yrs. | | | |
| { | | DUE TO | | (c) _____ | | | | | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY ARTERIOSCLEROTIC HEART DISEASE | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from SEPTEMBER 19, 1960 , to Feb. 22, 1960 , that I last saw the deceased alive on Feb. 22, 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 5801-16 West, N.W., Wash., D.C. | | | | | | | | DATE SIGNED 2-23-60 | |
| ACTUAL SIGNATURE Israel Kessler | | | | | | | | | |
| PHYSICIAN'S NAME (Type) ISRAEL KESSLER, MD. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-24-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM King David Memorial Garden | | 22d. LOCATION (City, town, or county) Falls Church, Virginia | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons | | ADDRESS 3501 14th St., N.W. | | 24a. REC'D BY REGISTRAR DATE FEB 25 '60 | | 24b. REGISTRAR'S SIGNATURE Caron S. Trahan | | | |



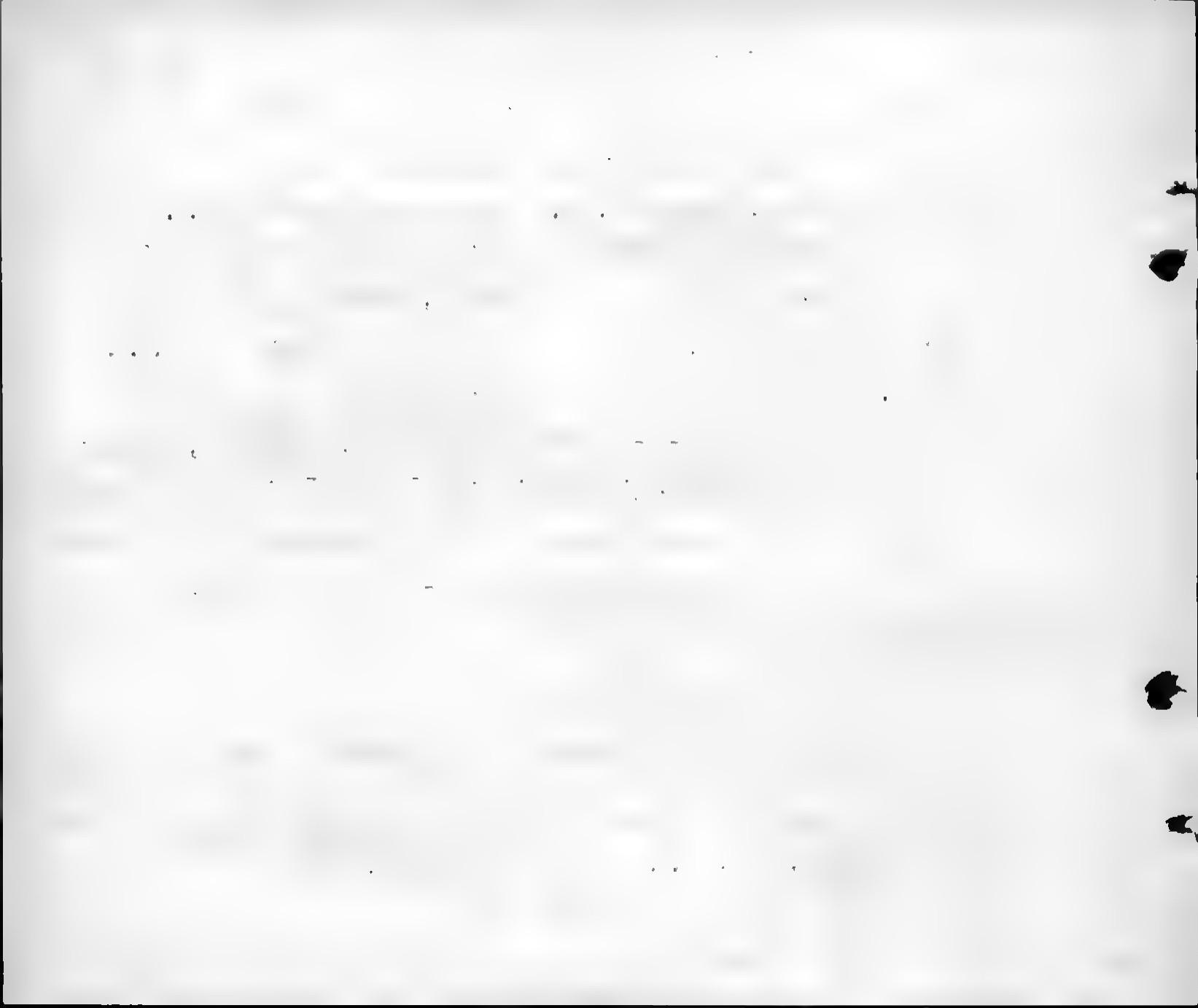
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2279 CERTIFICATE OF DEATH

02257

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 56 days | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | e. STREET ADDRESS 926 Massachusetts Avenue, N.W. | |
| 3. NAME OF DECEASED (Type or print) Clarence Thomas Smith | | First | Middle | Last | 4. DATE OF DEATH Month February Day 3 Year 1960 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 17, 1903 | 9. AGE (In years lost birthday) 56 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) District of Columbia | |
| 13. FATHER'S NAME Robert L. Smith | | 14. MOTHER'S MAIDEN NAME Marilla Allen | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, if yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 196-24-0071 | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 144X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO Epidermoid carcinoma posterior mediastinum (c) DUE TO Epidermoid carcinoma mouth - no local recurrence | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Pneumonia | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 9, 1959 , to February 3, 1960 , that I last saw the deceased alive on February 3, 1960 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Seymour C. Nash</i> M.D. The Clinical Center PHYSICIAN'S NAME (Type) Seymour C. Nash, M.D. National Institutes of Health Bethesda 14, Maryland | | | | ADDRESS (Street, city or town, state) 2-4-60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 22b. DATE THEREOF Feb. 5, 1960 | | 22c. NAME OF CEMETERY OR CREMATORIAL Hees Crematory | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee</i> | | ADDRESS Wash. D. C. | | 24a. REC'D BY REGISTRAR DATE FEB 8 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Curran S. Thomas | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2280

CERTIFICATE OF DEATH

Reg. Dist. No.

02258

| | | | | | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|----------------------------------|--|--|--------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 7 DAYS | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First FRANCES | Middle NEWMAN | Last SMITH | 4. DATE OF DEATH FEBRUARY 2 1960 | Month Day Year | | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/8/89 | 9. AGE (in years last birthday) 70 yrs. | F UNDER 1 YEAR Months Days | I F UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME GEORGE NEWMAN | | 14. MOTHER'S MAIDEN NAME HARRIETT HALL | | INFORMANT | | Address OLNEY, MD. | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. INFORMANT | | | | | | | | | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Canceromatosis DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of uterus (c) Bilateral, Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 1 yr | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) 198 | | (County) 2/2 | | (State) 1960 | |
| 21. I certify that I attended the deceased from alive on 2/2 1960 , and that death occurred at 11:05A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| ADDRESS (Street, city or town, state) 22. DATE SIGNED 2/2/60 | | | | | | | | | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) C. H. LOGAN, M.D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/7/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Westview Cemetery | | 22d. LOCATION (City, town or county) SANDY SPRING | | (State) MARYLAND | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Johnson | | ADDRESS Potomac, Md. | | 24a. REC'D BY REGISTRAR John G. Thomas | | 24b. REGISTRAR'S SIGNATURE John G. Thomas | | DATE FEB 10 1960 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2281

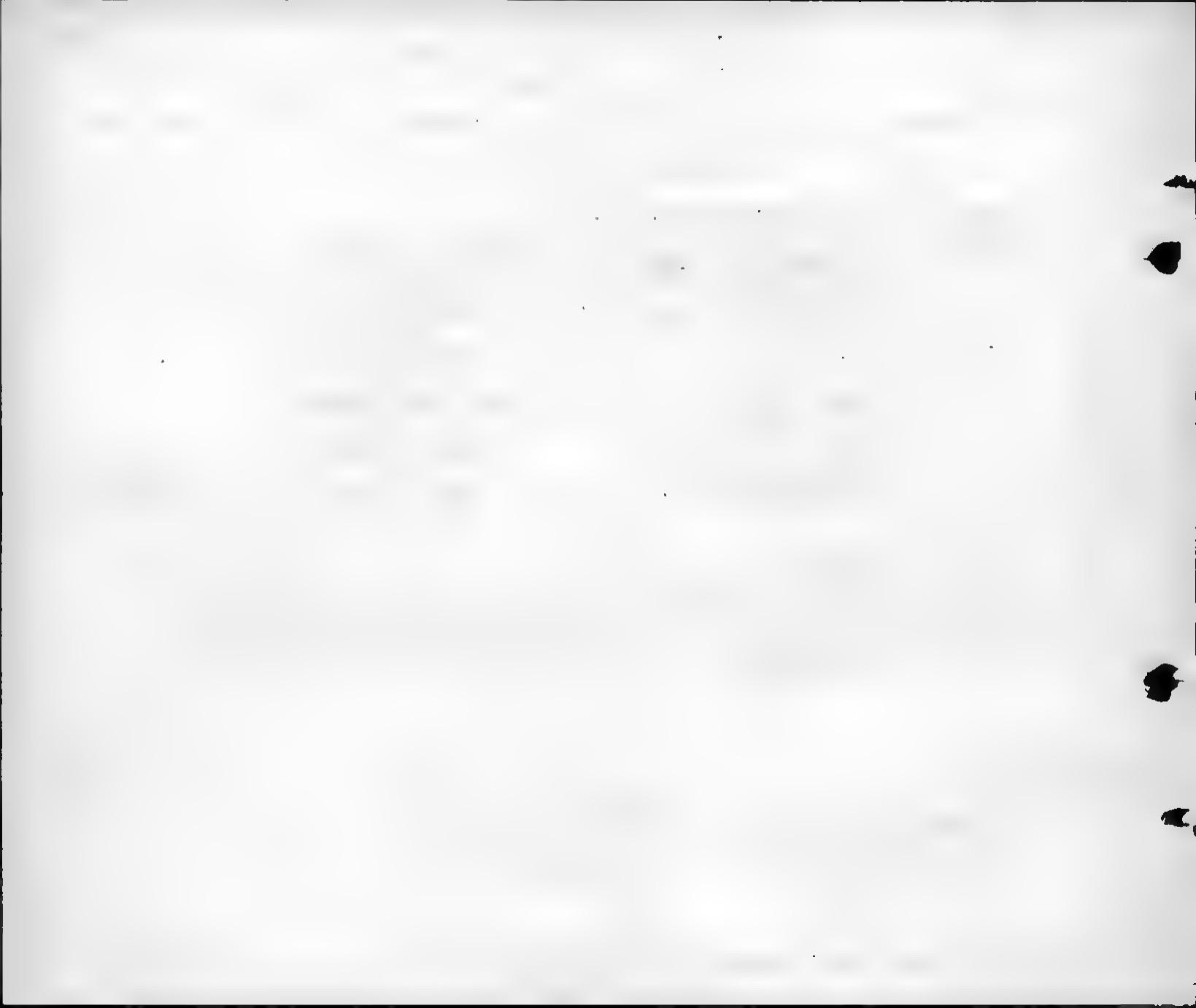
CERTIFICATE OF DEATH

Reg. Dist. No.

02259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|------------------------------------|--|---|--|--|---|-----------------------|----------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 11 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | d. STREET ADDRESS Rt. 1 | | | |
| Montgomery County General Hosp. Inc. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Lillie | Middle Belle | Last Smith | 4. DATE OF DEATH February 2 1960 | Month | Day | Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/25/01 1901 | | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Henry Greenwood | | | | 14. MOTHER'S MAIDEN NAME Mary Susan Winters | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | INFORMANT Hospital Record | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Arteriosclerotic heart disease with long time failure</i> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Thyroid adenoma, chronic secondary anemia, chronic bronchitis.</i> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>fall down</i> | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) DAMASCUS | (County) MD | (State) MD | |
| 21. I certify that I attended the deceased from January 2 1960 , that I last saw the deceased alive on Feb 2 1960 , and that death occurred at 6:25 P.M. from the causes and on the date stated above | | | | | | | | | |
| ADDRESS (Street, city or town, state) MAIN ST. | | | | | | | | | |
| ACTUAL SIGNATURE <i>G. F. Meadors, M.D.</i> | M.D. | | DATE SIGNED 2/2/60 | | | | | | |
| PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D. | DAMASCUS, MD. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/5/60 | 22c. NAME OF CEMETERY OR CREMATORIUM WINTERS CEM | | 22d. LOCATION (City, town, or county) CARROLL COUNTY MD | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Hartzel & Sons, New Windsor, Md.</i> | | ADDRESS <i>New Windsor, Md.</i> | | 24a. REC'D BY REGISTRAR FEB 5 '60 | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i> | | | | |
| VS A15 (4) 1SM 9/58 | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2282

CERTIFICATE OF DEATH

Reg. Dist. No.

02260

| | | | |
|---|--|---|------------------------|
| 1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 8 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban hospital | | e. STREET ADDRESS 1 5907 Lone Oak Drive | |
| 3. NAME OF DECEASED (Type or print) Louise C Smith | | 4. DATE OF DEATH February 8 | Month Day Year 1960 |

| | | | | | |
|------------------|---------------------------|---|---------------------------------------|--|---|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Jan uary 23, 1896 | 9. AGE (in years last birthday) 64 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| | | DIVORCED <input type="checkbox"/> | | | |

| | | | |
|---|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H swf. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Buxton, Maine | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|-----------------------------------|--|--|

| | | | |
|--|---|--------------------------------------|-----------------------|
| 13. FATHER'S NAME Mark Rounds | 14. MOTHER'S MAIDEN NAME Fannie Palmer | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, if yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. yes | INFORMANT Mrs H attie Stone above | Address (daughter) |

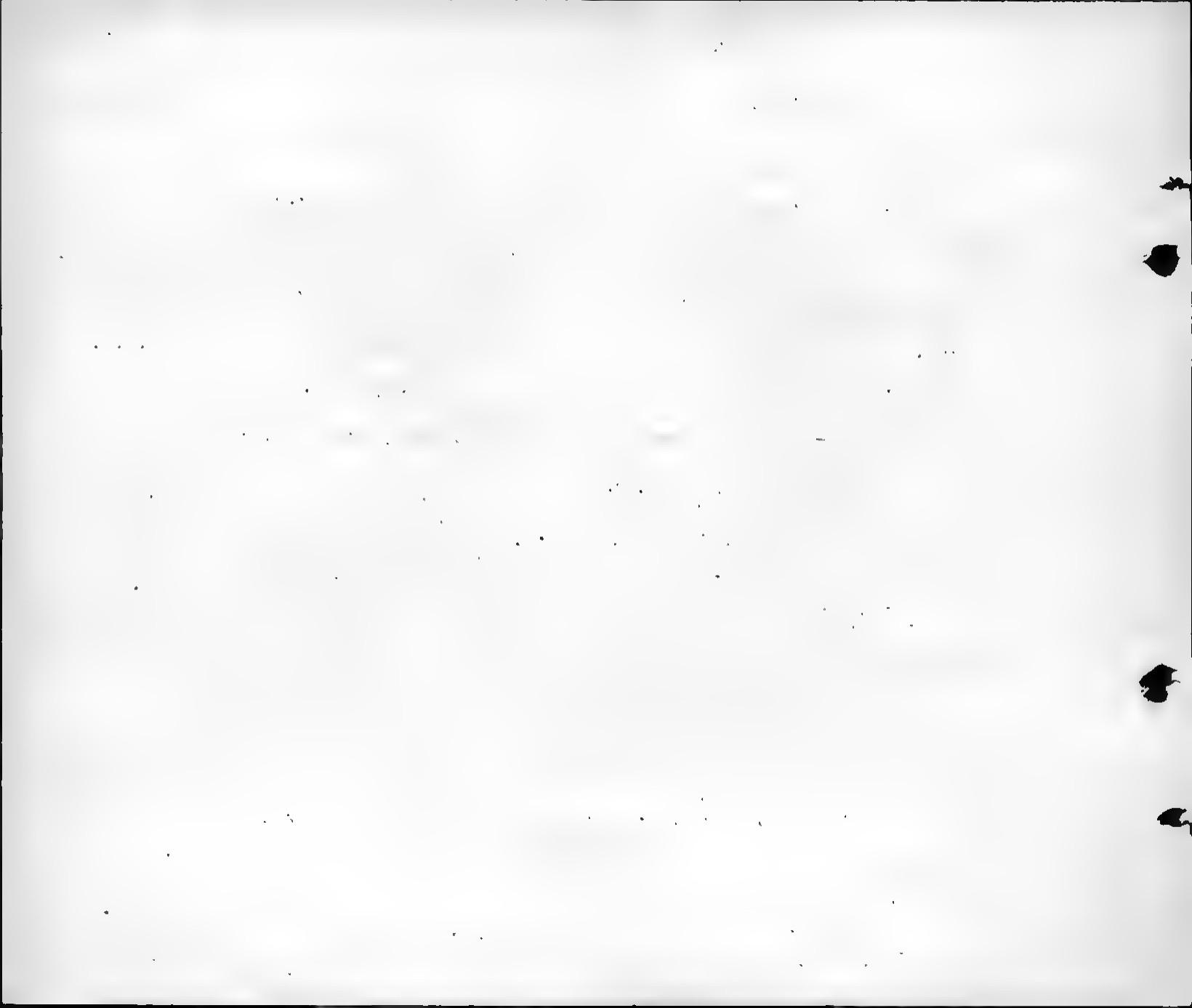
| | | |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mycocardial insufficiency</i> 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Mycocardial hypertrophy and dilatation</i> DUE TO (c) <i>Rheumatic mitral & tricuspid valvularis</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 week years years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <i>ostent foramen ovale</i> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

| | | | |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | | |
|--|---|------------------------------|
| 21. I certify that I attended the deceased from alive on <i>2/7/1960</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above. | ADDRESS (Street, city or town, state) <i>4890 BATTERY LA</i> | DATE SIGNED <i>2/8/60</i> |
|--|---|------------------------------|

| | | | | | |
|--|---|---|--------------------------------|---|--|
| ACTUAL SIGNATURE <i>Charles J. Savarese, M.D.</i> | PHYSICIAN'S NAME (Type) <i>CHARLES J. SAVARESE, M.D.</i> | BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i> | DATE THEREOF <i>2/10/60</i> | NAME OF CEMETERY OR CREMATORIAL <i>Pine Grove Cemetery</i> | LOCATION (City, town, or county) <i>Waterville, Maine</i> |
|--|---|---|--------------------------------|---|--|

| | | | |
|--|--|---------------------------------------|--|
| FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i> | ADDRESS <i>5103 Washington Street</i> | REC'D BY REGISTRAR DATE FEB 10 '60 | REGISTRAR'S SIGNATURE <i>Charles S. Knott</i> |
|--|--|---------------------------------------|--|



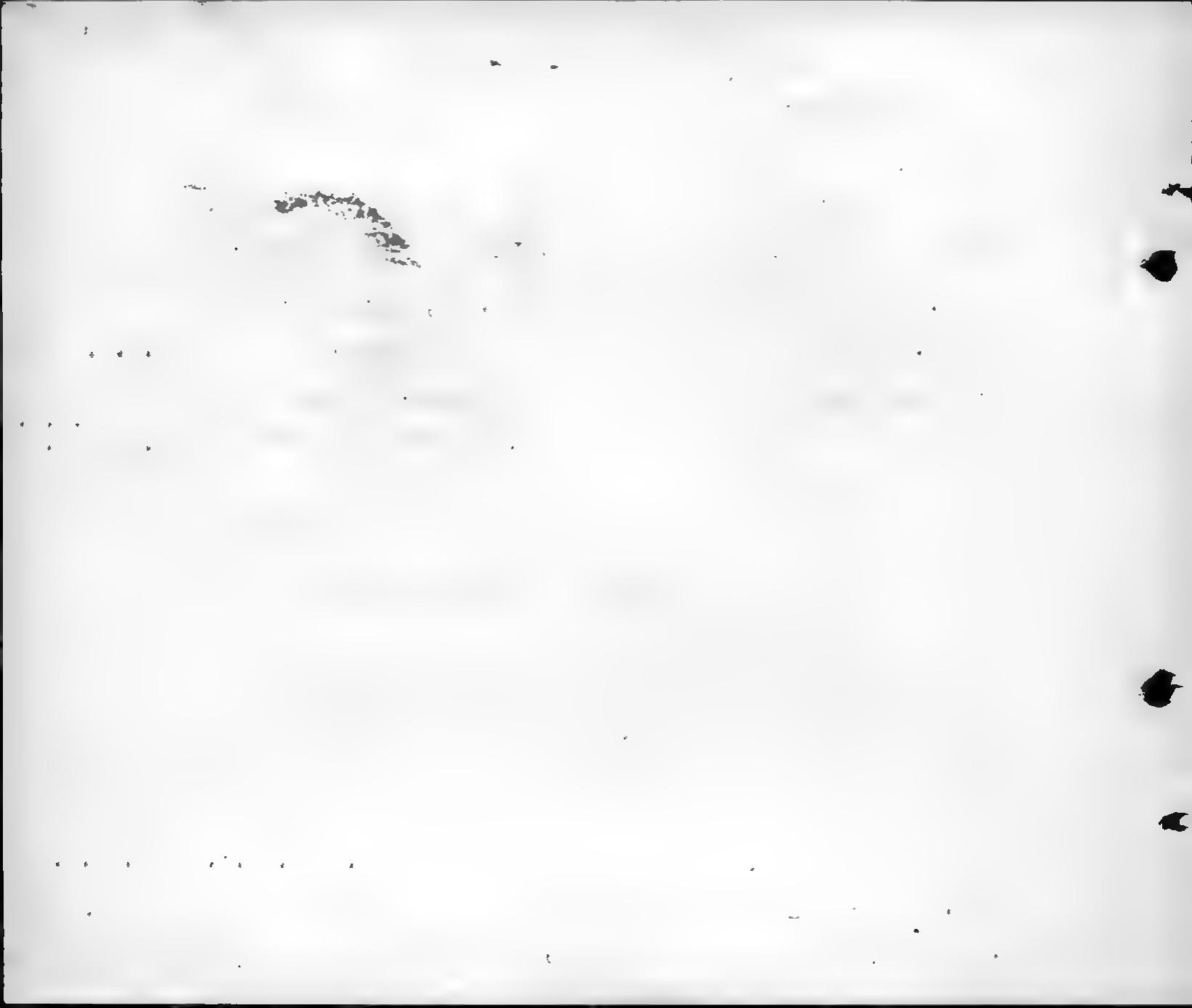
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G28 3-7-60 et
2283 CERTIFICATE OF DEATH

(12261)

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|--|--|---|--|---|-----------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland | | b. COUNTY Montgomery D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown | | c. LENGTH OF STAY IN lb RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS Cathedral Arts. Nr. Gaithersburg, Maryland. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Home | | | | d. STREET ADDRESS 47X-3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First NELLIE | Middle Middle | Last SMITH | 4. DATE OF DEATH | Month February | Day 26 | Year 1960 |
| 5. SEX F. | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH NOV. 26, 1877 | 9. AGE (In years last birthday) 82 | 10. IF UNDER 1 YEAR Months 82 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Retired | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BARTRAM NAUSS | | 14. MOTHER'S MAIDEN NAME MARGARET YINGER | | INFORMANT Address Mrs. Sargent (Daughter) 220 E. 73 St. N.Y.C. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. - - - - - | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerotic Heart disease (c) DUE TO Arterio. disease, generalized | | | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| | | | | YEAR years | | | |
| | | | | YEARS years | | | |
| 18. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(a) Senile dementia | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) | | 20f. (City or town) (County) (State) 1150 Conn. Ave., Wash. D.C. | |
| 21. I certify that I attended the deceased from Feb. 1, 1955 , to Feb 25, 1960 , that I last saw the deceased alive on Feb. 21, 1960 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Frederic D. Chapman M.D. | | ADDRESS (Street, city or town, state) 1150 Conn. Ave., Wash. D.C. | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) FREDERIC D. CHAPMAN | | 22b. DATE THEREOF 2-29-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL | | 22d. LOCATION (City, town, or county) SUITLAND, MD. (State) | |
| 22e. BURIAL, CREMATION, OR Cremation SPECIFY CREM. | | 22f. ADDRESS Washington, DC | | 24a. REC'D BY REGISTRAR DATE MAR 1 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Mead | |
| 26. FUNERAL DIRECTOR'S SIGNATURE Joseph Shuler's Sons | | | | | | | |

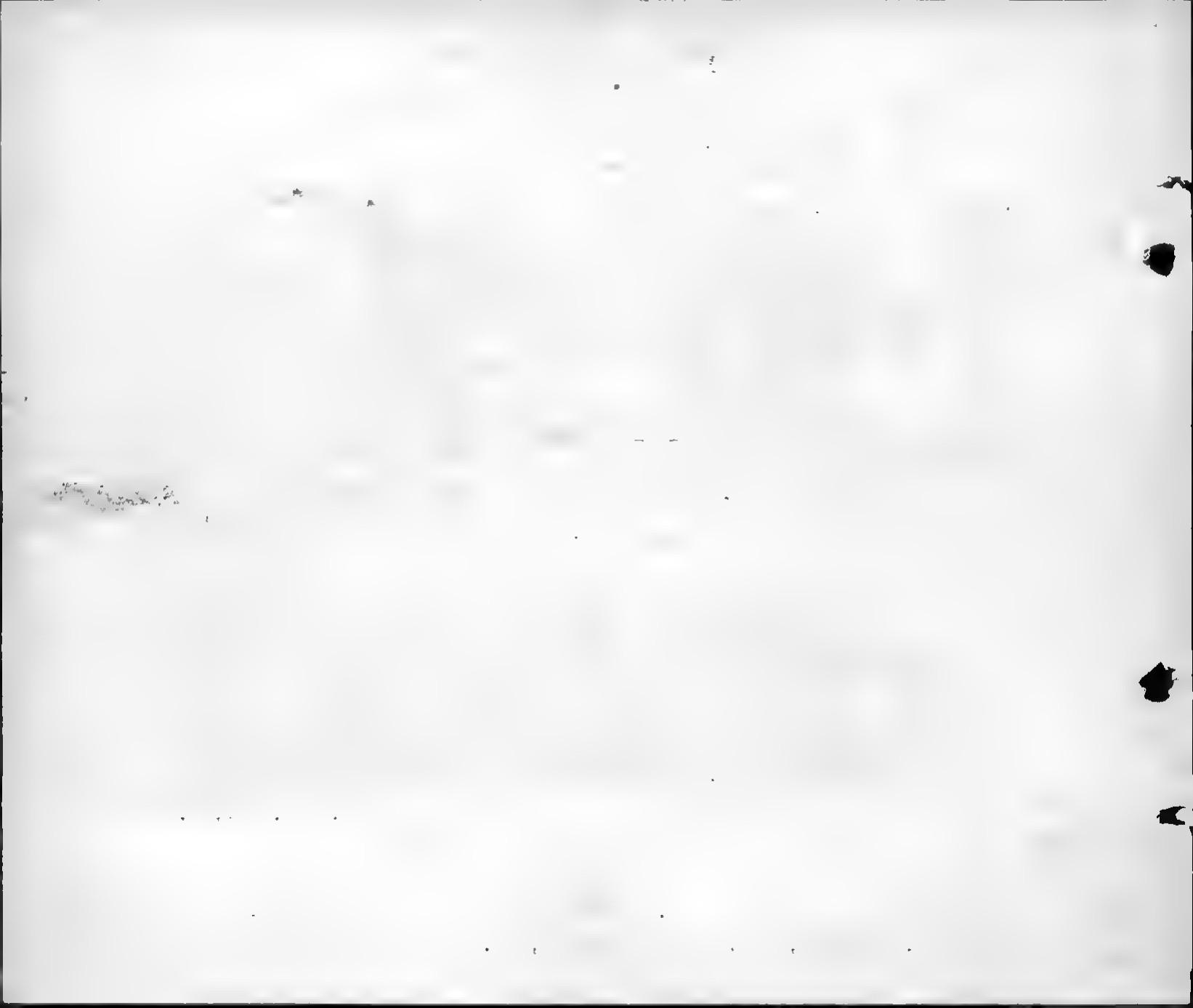


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2158 CERTIFICATE OF DEATH

112262

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE | |
| Montgomery MARYLAND | | Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate lim. write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 109 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Wesley Dow Smith | | DATE OF DEATH Last Month Day Year | Feb 14 1960 |
| 4. SEX Male White | | 5. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 18, 1904 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Staff - Matl. Rifle Assoc | 11. KIND OF BUSINESS OR INDUSTRY Rifle Clubs |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | 13. FATHER'S NAME William Smith | |
| 14. MOTHER'S MAIDEN NAME Mrs Clara Clodfelter | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? No | |
| 16. SOCIAL SECURITY NO 364-14-6549 | | 17. INFORMANT Dr. Mrs Ruth Smith | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | Acute Coronary Occlusion Myocardial infarction - Acute. INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 14, 1960, to Feb 14, 1960, that I last saw the deceased alive on Feb 14, 1960, and that death occurred at 10:25 PM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 8323 Haddon Dr. Tak. Pk., Md. DATE SIGNED 2/14/60 | |
| ACTUAL SIGNATURE Wilford D. Meyers M.D. | | PHYSICIAN'S NAME (Type) Wilford D. Meyers MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 2/16/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL | | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC. | | 24a. REC'D BY REGISTRAR ADDRESS SILVER SPRING, MD. DATE FEB 17 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Lorraine S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02263

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--------------------------|---|-----------------------------|---|---------------------------|---|------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b 2 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 514 DOMER AVENUE | | | | d. STREET ADDRESS 514 DOMER AVENUE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First WILLIAM | Middle R | Last SMITH | 4. DATE OF DEATH FEB 13 1960 | Month | Day | Year |
| S SEX MALE | 6 COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH 5/10/87 | 9 AGE (In years lost birthday) 72 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR (Builder) | | 10b. KIND OF BUSINESS OR INDUSTRY Self-employed | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT SMITH | | | | 14. MOTHER'S MAIDEN NAME LUCY MOSS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO 578-14-9088 | | INFORMANT Mr. Charles R. Smith, 1121 Caddington Ave. | | Address Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED DUE TO ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH YEARS 450. - (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARCINOMA OF THE LUNG. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | (County) (State) |
| 21. I certify that I attended the deceased from MARCH 1958, to FEB. 13 1960, that I last saw the deceased alive on FEB. 12 1960, and that death occurred at 12:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ABRAHAM W. DANISH, M.D. 927 PEASHTON DR. DATE SIGNED 2-14-60 | | | | | | | |
| ACTUAL SIGNATURE <i>Abraham W. Danish</i> | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH, M.D. | | SILVER SPRING, MD. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS & BURIAL 2/16/60 | | 22b. DATE THEREOF GRACELAND CEMETERY | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) GREENVILLE, SOUTH CAROLINA (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE RAYN R. E. PUMPREY, INC. <i>Raymond R. E. Pumfrey</i> | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE FEB 16 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Phane | |



18

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Item 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

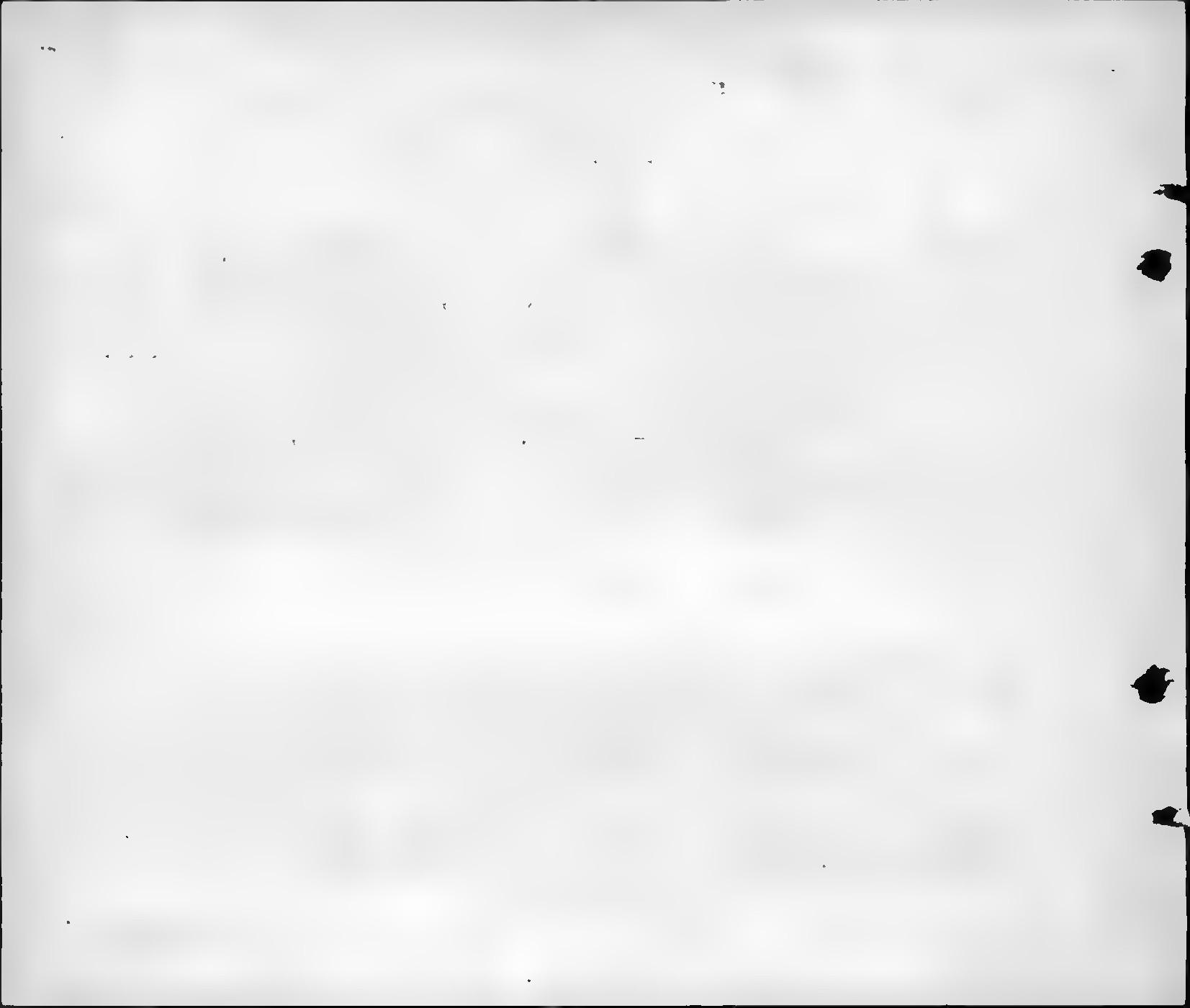
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02264

Reg. Dist. No.

2128

| | | | |
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| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 944 BONIFANT STREET | | d. STREET ADDRESS Goshen School Road | |
| e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Charles WILLIAM | First Fenton | Middle SNOUFFER | 4. DATE OF DEATH FEB. 24 1960 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 13, 1906 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Cycle Shop | 9. AGE (In years from birthday) 53 yrs. |
| 13. FATHER'S NAME Charles Snouffer | | 14. MOTHER'S MAIDEN NAME Lucy Brady | 11. BIRTHPLACE (State or foreign country) Maryland |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-05-6026 | 17. INFORMANT Mrs. Josephine Snouffer, Item #2 Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause last. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2/24/60 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/27/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven | 22d. LOCATION (City, town, or county) Montgomery, Md. (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber | ADDRESS Laytonsville, Md. | 24a. REC'D BY REGISTRAR FEB 29 '60 | 24b. REGISTRATION SIGNATURE Arthur J. Knarr |
| VS. A15ME SM 2/57 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12265)

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg R-2</i> | | c. LENGTH OF STAY IN 1b <i>4 mos</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pleasant View Nursing Home</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Derwood - R-1</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Phoebe Waters Snowden</i> | | d. STREET ADDRESS <i>mt Zion</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Phoebe Waters Snowden</i> | | 4. DATE OF DEATH <i>Feb</i> | Month Year <i>1960</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>col</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>5-14-1866</i> |
| 8. DATE OF BIRTH <i>93 yrs.</i> | | 9. AGE (In years last birthday) <i>93 yrs.</i> | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> |
| 13. FATHER'S NAME <i>✓</i> | | 14. MOTHER'S MAIDEN NAME <i>✓</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Nursing Home</i> |
| | | | Address <i>Stine - 1</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Acute Congestive heart failure</i> | | | |
| DUE TO <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | DATE SIGNED <i>Sept 1 1960</i> | |
| ACTUAL SIGNATURE <i>Frank J. Bloschany</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>Frank J. Bloschany</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>McGuire Funeral Home., Washington, D. C.</i> | |
| 22a. BURIAL CREMATION & REMOVAL <i>2/2/60</i> | | 22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i> | |
| 23. FUNERAL DIRECTOR & SIGNATURE <i>Robert L. Snowden</i> | | ADDRESS <i>Rockville, Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>FEB 5 '60</i> |
| | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2285

CERTIFICATE OF DEATH

Reg. Dist. No.

02266
215

| | | | | |
|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN lb 6 days |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | f. STREET ADDRESS 6809 Algonquin Ave. |

| 3. NAME OF DECEASED (Type or print) | First Clara | Middle Alberta | Last SNYDER | 4. DATE OF DEATH February 2 | Month February | Day 2 | Year 1960 |
|--|-----------------------|--------------------------|-----------------------|---------------------------------------|--------------------------|-----------------|---------------------|
|--|-----------------------|--------------------------|-----------------------|---------------------------------------|--------------------------|-----------------|---------------------|

| | | | | | | | |
|-------------------------|--------------------------------------|---|-----------------------------------|--|--|-------------------------------------|---|
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-7-80 | 9. AGE (in years last birthday) 79 yrs | IF UNDER 1 YEAR Months 79 | IF UNDER 24 HRS Days 0 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|-------------------------|--------------------------------------|---|-----------------------------------|--|--|-------------------------------------|---|

| | | | |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|--|--|

| | | | |
|---|--|--------------------------------------|---------|
| 13. FATHER'S NAME David Myers | 14. MOTHER'S MAIDEN NAME Alberta James | INFORMANT Hospital Records | Address |
|---|--|--------------------------------------|---------|

| | | |
|---|----------------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. ----- | INTERVAL BETWEEN ONSET AND DEATH ----- |
|---|----------------------------------|---|

| | |
|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma, multiple DUE TO ----- | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) ----- | INTERVAL BETWEEN ONSET AND DEATH ----- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic heart disease | |

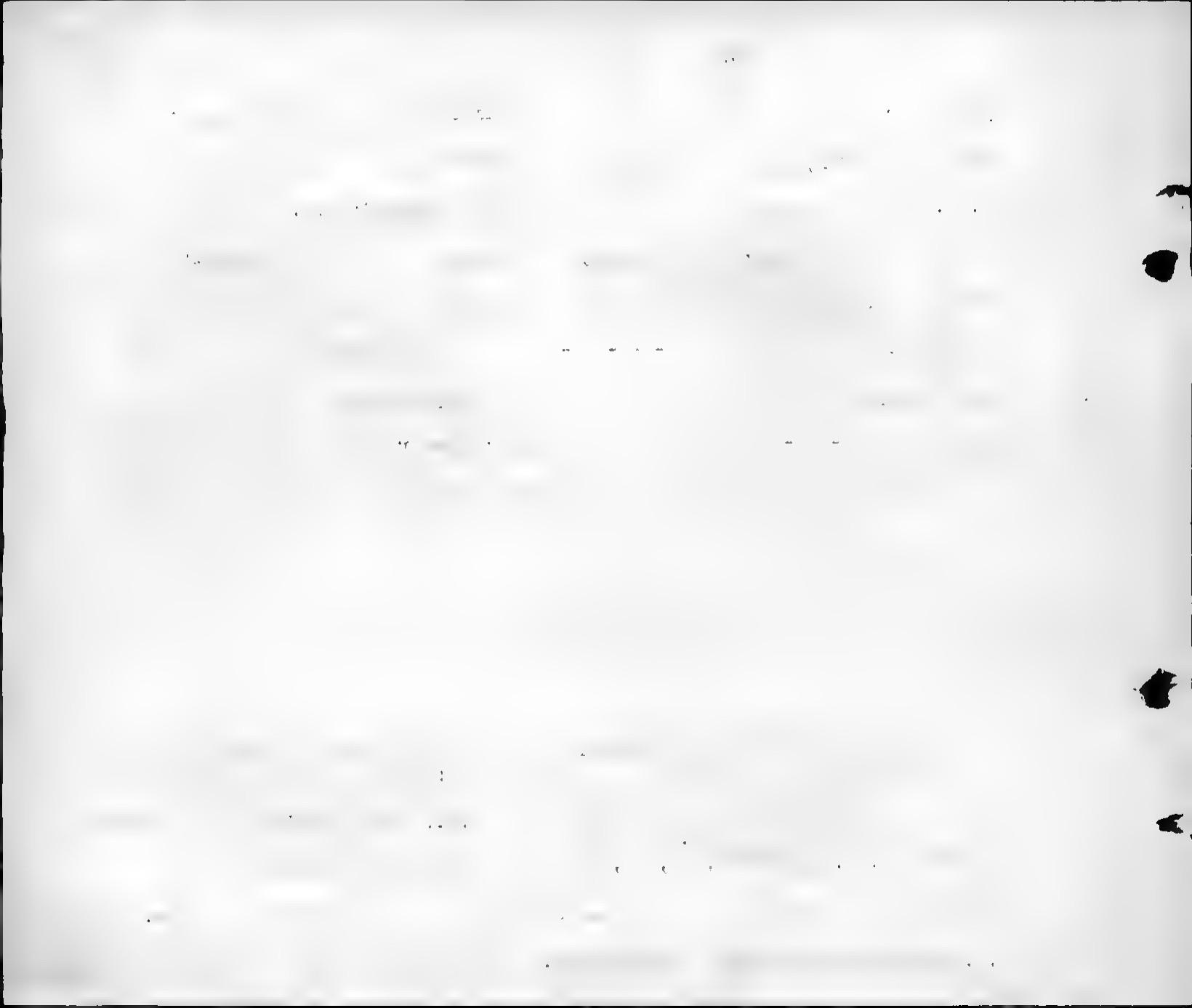
| | | | | |
|--|--|---|------------------------------|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) ----- | 20f. (City or town) ----- | (County) (State) ----- |

| | | |
|--|--|------------------------------|
| 21. I certify that I attended the deceased from January 27, 1960 , to February 2, 1960 , that I last saw the deceased alive on February 2, 1960 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. | ADDRESS (Street, city or town, state) ----- | DATE SIGNED 2-3-60 |
|--|--|------------------------------|

| | | |
|--|-----------------------|----------------------|
| ACTUAL SIGNATURE <i>R.G. Galbraith Jr.</i> | M.D. ----- | U. S. Naval Hospital |
| PHYSICIAN'S NAME (Type) R. G. GALBRAITH, LT, MC, USN | Bethesda 14, Maryland | |

| | | | | |
|---|------------------------------------|--|--|-----------------------|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | 22b. DATE THEREOF 2-4-60 | 22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Cemetery | 22d. LOCATION (City, town, or county) Whitemarsh | (State) Pa. |
|---|------------------------------------|--|--|-----------------------|

| | | | |
|---|---|---|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charlton S. Finane</i> | ADDRESS R.A. Pumphrey Funeral Home, Bethesda, Md. | 24a. REC'D BY REGISTRAR DATE FEB 4 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Finane</i> |
|---|---|---|---|



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2286 CERTIFICATE OF DEATH

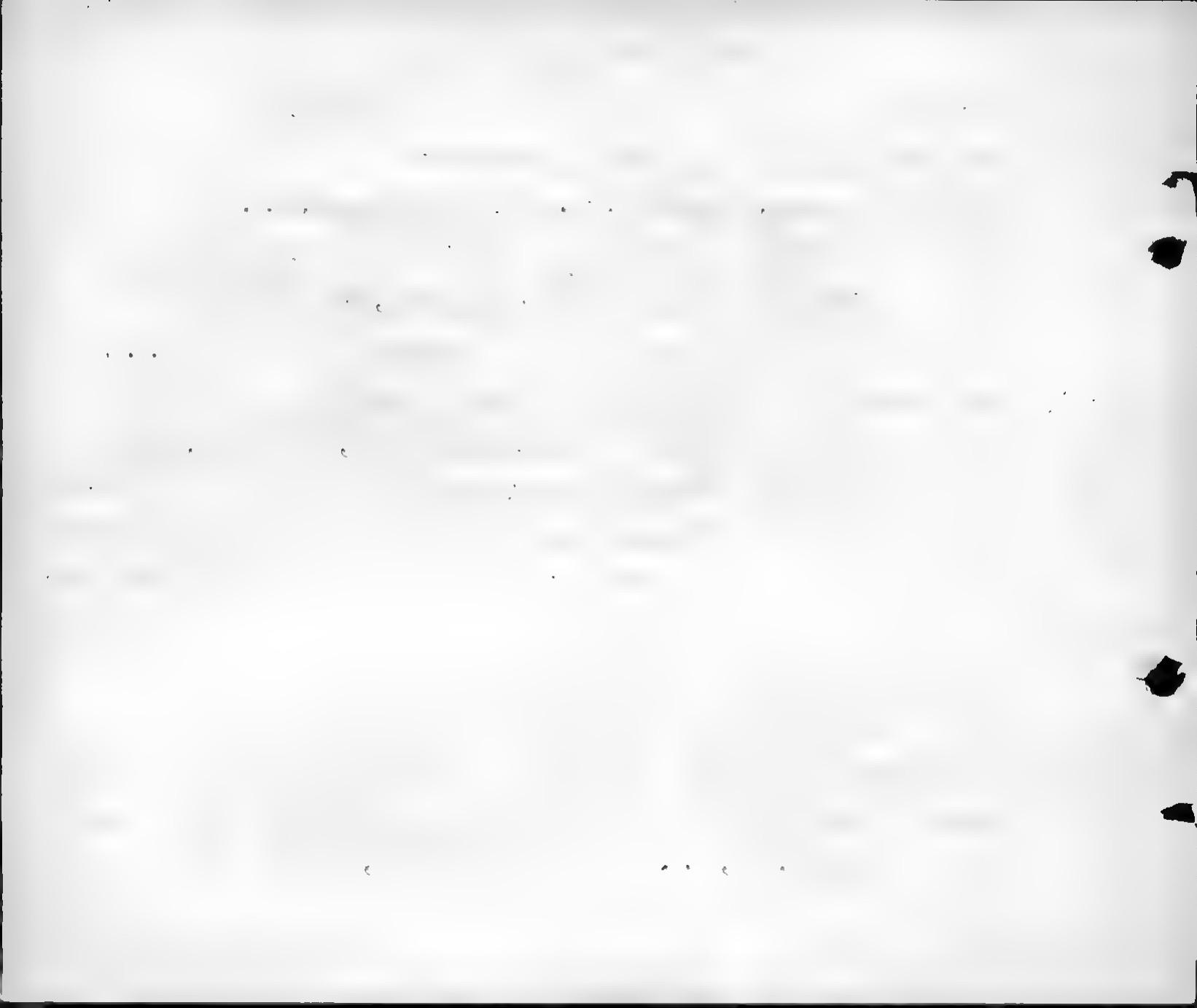
Reg. Dist. No.

102267

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached [for use as the burial-transit permit]. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---------------------------|---|--|---|-----------------------------------|--|
| 1 PLACE OF DEATH COUNTY Montgomery | | MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE District of Columbia | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c LENGTH OF STAY IN lb 3 days | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d STREET ADDRESS 1618 Myrtle Street, N.W. | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3 NAME OF DECEASED (Type or print) | First David | Middle Benjamin | Last Sosnik | 4. DATE OF DEATH February | Month 27 | Day Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH September 14, 1943 | 9. AGE (in years last birthday) 16 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11 BIRTHPLACE (State or foreign country) New York | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13 FATHER'S NAME Harry Sosnik | | | 14 MOTHER'S MAIDEN NAME Sophia Feldmann | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Pulmonary Hypertension | | Ventricular Fibrillation | | INTERVAL BETWEEN ONSET AND DEATH 30 minutes | | |
| (c) DUE TO Pulmonary Vascular Obstruction | | | | 6 months | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from February 21, 1960, to February 27, 1960, that I last saw the deceased alive on February 27, 1960, and that death occurred at 10:15A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | | DATE SIGNED 2/28/60 |
| ACTUAL SIGNATURE <i>Samuel M. Fox</i> | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | |
| PHYSICIAN'S NAME (Type) Samuel M. Fox, M.D. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 29, 1960 | | 22c. NAME OF CEMETERY OR CREMATORIUM BETH SHOLOM CEMETERY | | 22d. LOCATION (City, town or county) HILL SIDE (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons | | ADDRESS 3501-14 ST. N.W. | | 24a. REC'D. BY REGISTRAR MAR 1 '60 DATE | | 24b. REGISTRAR'S SIGNATURE <i>Albert J. Flannery</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2129

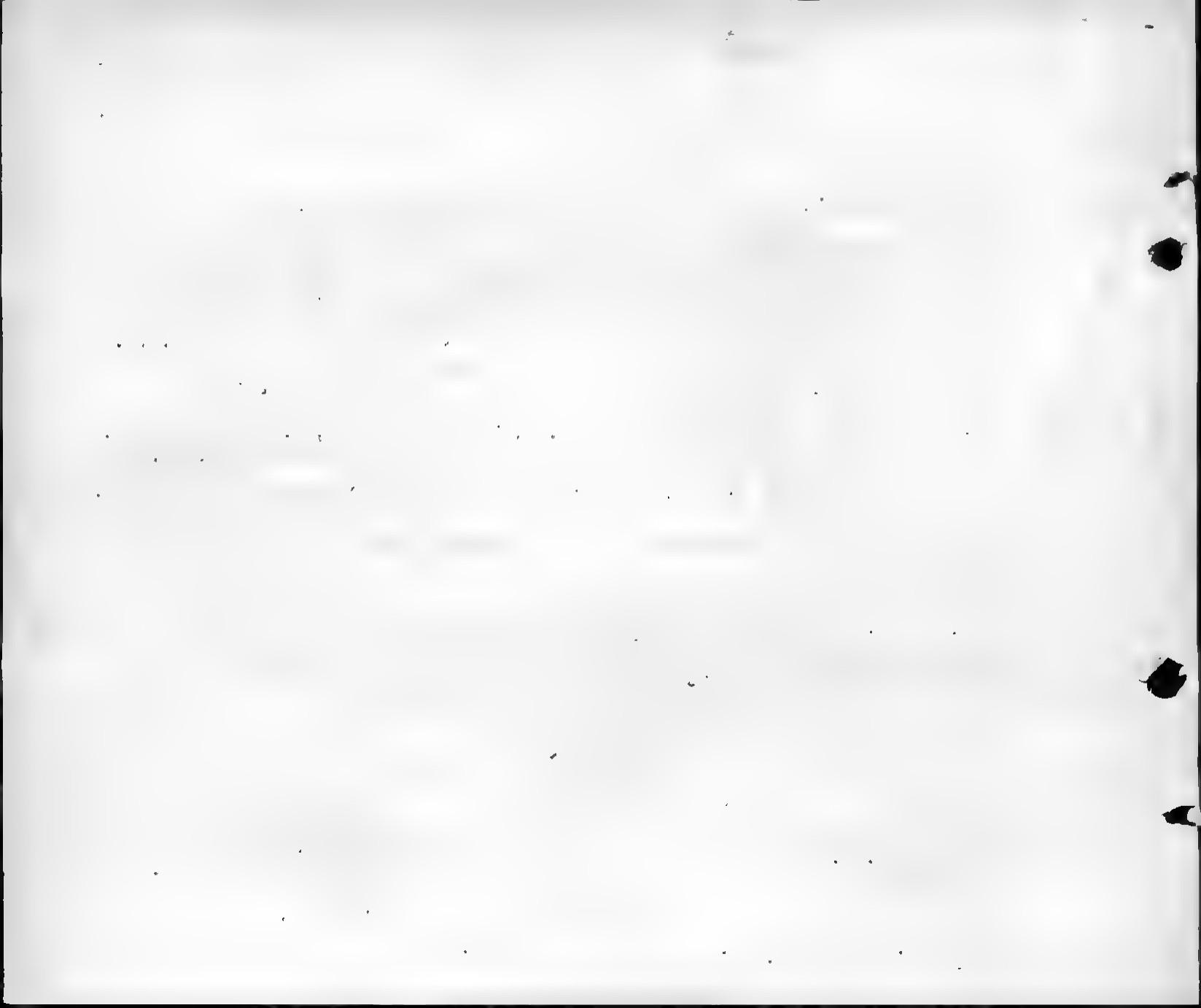
CERTIFICATE OF DEATH

02268

Reg. Dist. No.

| | | | |
|--|---|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b Since 1929 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9505 WOODLEY AVE. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| 3. NAME OF DECEASED (Type or print) EDWARD ROBINSON STABLER | | First | Middle |
| 4. DATE OF DEATH FEBRUARY 15 | Month | Day | Year 19 60 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/16/57 |
| 9. AGE (in years last birthday) 102 | 10. IF UNDER 1 YEAR Months 102 | 11. IF UNDER 24 HRS. Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBINSON STABLER | | 14. MOTHER'S MAIDEN NAME MARY HARTSHORNE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Mr. E. Kenneth Stabler, 9505 Woodley Ave. | | Address Forest Glen, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary insufficiency & occlusion DUE TO 420.1 Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 hours | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) secondary effects of advanced age (age 102) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) no injury | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/25/60 , 19, to 2/15/60 , 19, that I last saw the deceased alive on 2/15/60 , 19, and that death occurred at 9:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. L. Marston, M.D.</i> PHYSICIAN'S NAME (Type) E. L. Marston | | ADDRESS (Street, city or town, state) 800 Pershing Drive Silver Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/18/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM WOODSIDE CEMETERY | | 22d. LOCATION (City, town, or county) BRINKLOW, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. HUMPHREY INC. <i>Raymond J. Ziska</i> | | 24a. REC'D BY REGISTRAR DATE FEB 18 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Curtis J. Kraut</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2287

CERTIFICATE OF DEATH

(12269)

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|--|---------------------------------------|--|------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | | b. COUNTY HOWARD MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 9 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First SHERRI | Middle DARLENE | Last STEVENSON | 4. DATE OF DEATH FEBRUARY 10 1960 | Month FEBRUARY | Day 10 | Year 1960 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/1/60 | 9. AGE (in years lost birthday) yrs. 9 | IF UNDER 1 YEAR Months 9 | IF UNDER 24 HRS Days 9 | Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES JUNIOR STEVENSON | | 14. MOTHER'S MAIDEN NAME LIZA JANE WRIGHT | | INFORMANT | | Address OLNEY, Md. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 40-00000000 | | HOSPITAL RECORDS | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Part III. MEDICAL CERTIFICATION | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/1/60 to 2/10/60 , that I last saw the deceased alive on 2/10/60 , and that death occurred at 6:40 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>[Signature]</i> | | ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND | | M.D. | | DATE SIGNED 2/11/60 | |
| PHYSICIAN'S NAME (Type) C. H. LIGON, M.D. | | 22c. NAME OF CEMETERY OR CREMATORY Bays Creek | | 22d. LOCATION (City, town, or county) Barnesville Md. | | (State) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-12-60 | | 24a. REC'D BY REGISTRAR DATE FEB 15 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Ruth | |
| 23. FUNERAL DIRECTOR'S SIGNATURE 2671. B. Hilton Barnesville Md. | | ADDRESS 2073348XVI | | | | | |



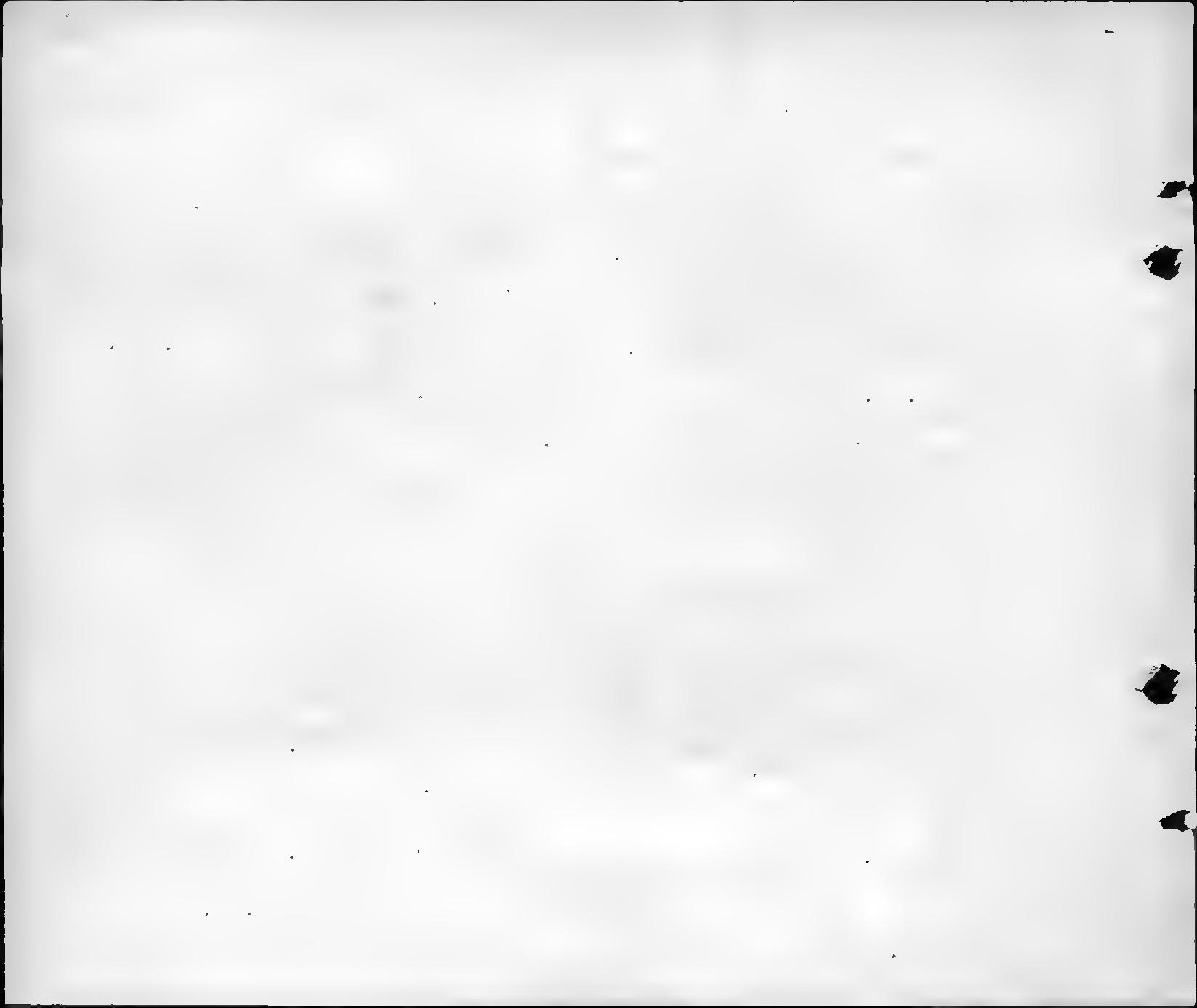
02270

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|----------------------------------|---|--|--|---------------------------------|--|----------------------------|--------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 2½ months | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | f. STREET ADDRESS 7501 Persimmon Tree Rd. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First LILLY | Middle C. | Last STONE | 4. DATE OF DEATH February 8, | Month February | Day 8 | Year 19 60 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 20, 1861 | 9. AGE (in years last birthday) 98 | 10. IF UNDER 1 YEAR 5 | 11. IF UNDER 24 HRS 18 | 12. Months Hours | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part Owner | | 10b. KIND OF PROPERTY Quarries | | 11. BIRTHPLACE (State or foreign country) Stoneyhurst Stone Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME John D. W. Moore | | 14. MOTHER'S MAIDEN NAME Sara B. Coltman | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 220-32-5527 | | 17. INFORMANT J. Dunbar Stone- Item #2 - Son | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X | | DUE TO Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Broncho pneumonia | | (c) | | 10 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from February 7, 1960 , to Feb. 8, 1960 , that (I) (we) lost saw the deceased alive on Feb. 7, 1960 , and that death occurred 4:35 AM from the causes and on the date stated above | | 22a. SIGNATURE <i>Robert G. Angle</i> | | 22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE NAMED 2/8/60 | | | |
| 22c. PHYSICIAN'S NAME (LVE) Robert G. Angle | | 22d. ADDRESS 5009 Del Ray Ave., Bethesda, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2-10-60 | | 23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery | | 23d. LOCATION (City, town, or county) Washington, D. C. (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE FEB 9 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2176 Items 8, 9, 11, 12, 14-16, 21-23, 26, 27

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION **Kensington Gardens Sanit.**
3000 McComas Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MD** b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D. C.

d. STREET ADDRESS
1300 Iris Street N. W.

e. IS RESIDENCE ON A FARM? **NO**

3. NAME OF DECEASED (Type or print) **Ernest B. Swingle**

First Middle Last

4. DATE OF DEATH **Feb 13 1960**

5. SEX **Male** **6. COLOR OR RACE** **White** **7. MARRIED** **NEVER MARRIED**
WIDOWED **DIVORCED**

8. DATE OF BIRTH **6/27/1878** **1868**

9. AGE (In years last birthday) **81 91 yrs.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Carpenter

10b. KIND OF BUSINESS OR INDUSTRY **11. BIRTHPLACE** (State or foreign country)
Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Unknown**

14. MOTHER'S MAIDEN NAME **unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? **no** **16. SOCIAL SECURITY NO.** **none** **17. INFORMANT** **Roy L. Cobb-1300 Iris St. N.W.** Address **Washington, DC**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | | |
|---|--|------------------------------------|--|
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | Teenager Pulmonary Embolism | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| 33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first | | Cerebral Accident | 2 1/2 yrs |
| (b) DUE TO | | Arterio - sclerosis | 10 yrs. |
| (c) DUE TO | | | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

| | | |
|--------------------------|--|---|
| Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--------------------------|--|---|

20a. ACCIDENT WAS UNDERLYING **OR CONTRIBUTING** **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. **19** **20d. INJURY OCCURRED**
p. m. **Not while at work** **at work**

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** **(County)** **(State)**

21. I certify that (I) (We) attended the deceased from **12/8/61** **to** **2/13/60**, **that (I) (We) lost**
saw the deceased alive on **2/13/60**, **and that death occurred at 25M, from the causes and on the date stated above.**

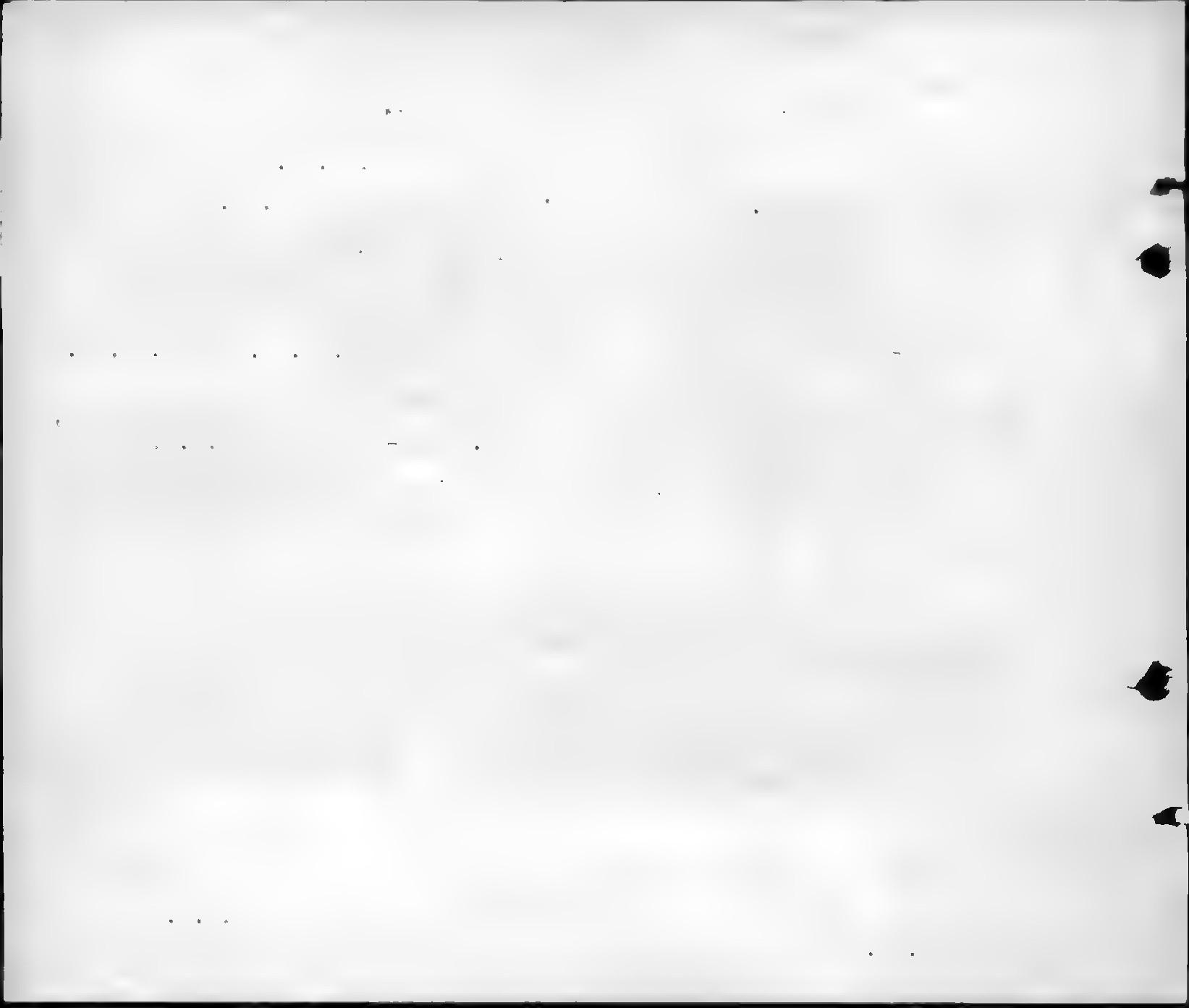
22a. SIGNATURE **Francis X. Richardson** M.D. **ATTENDING PHYS** **MED DIRECTOR** **STAFF PHYS** **22b. DATE SIGNED** **2/13/60**

22c. PHYSICIAN'S NAME (Type) **Francis X. Richardson** **22d. ADDRESS** **11412 Viers Mill Rd. Whitemarsh**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** **23b. DATE THEREOF** **2/16/60** **23c. NAME OF CEMETERY OR CREMATORIUM** **Rock Creek Cemetery** **23d. LOCATION (City, town, or county)** **Washington, D.C.** **(State)**

24. FUNERAL DIRECTOR'S SIGNATURE **The S. H. Hines Company** **ADDRESS**

25a. REC'D BY REGISTRAR **25b. REGISTRAR'S SIGNATURE**
DATE **FEB 16 '60** **Arthur S. Kraus**



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

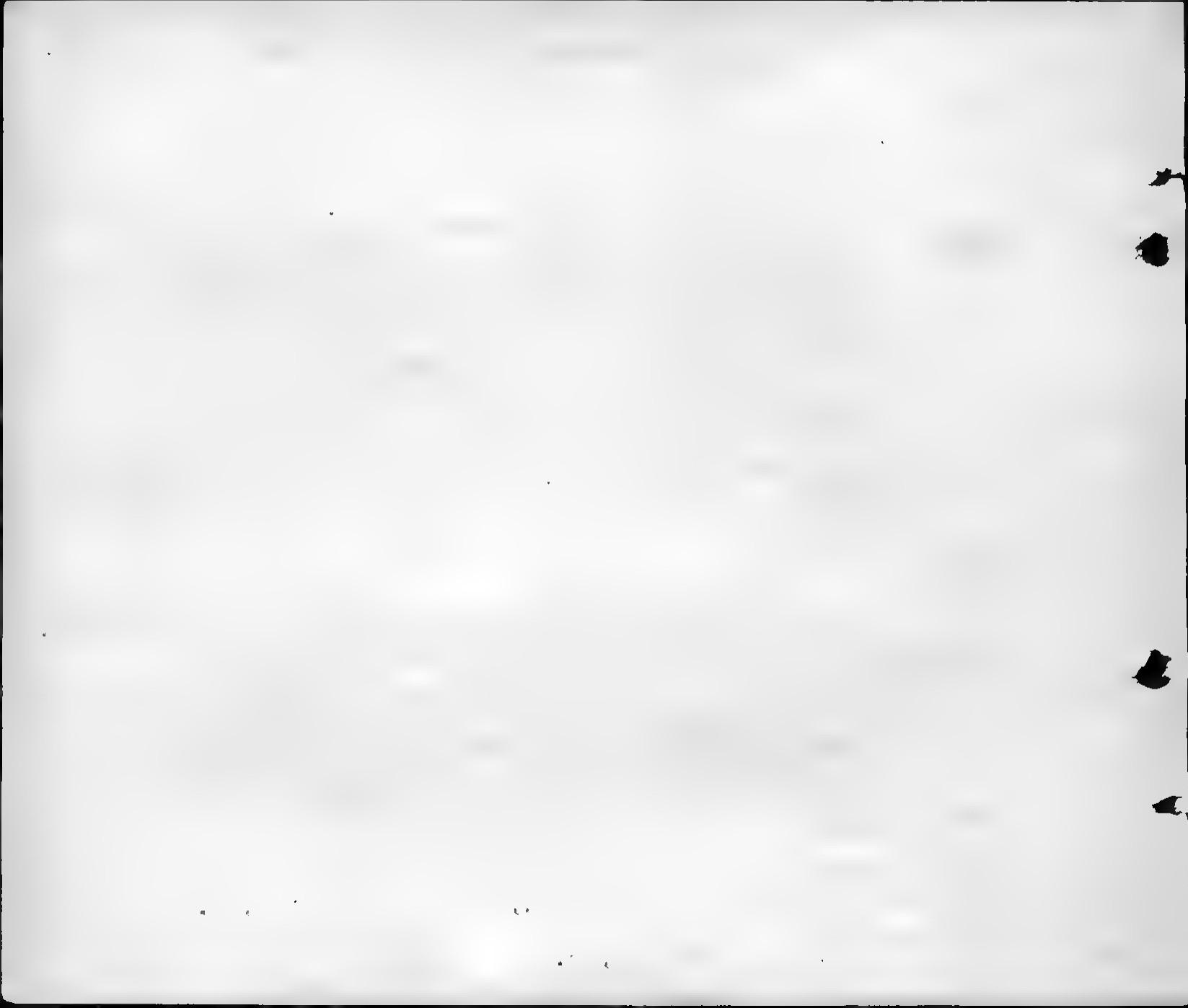
12272

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3, along with the death certificate. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be given to a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2283 | | 2. USUAL RESIDENCE (Where deceased lived if institutional; Residence before admission) | |
| Montgomery | | MARYLAND | | a. STATE | b. COUNTY |
| Rockville R-2 | | 22 yrs | | Md | Monty |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Seven Lakes Rd | | | | x Rockville R-2 | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | 4. DATE OF DEATH | |
| Emily Ann Thomas | | | | Feb | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years Incl b. birthday) |
| Female | | Widowed <input checked="" type="checkbox"/> | 2-2-1894 | 66 yrs | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Caterina | | | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Richard Miles | | Bessie Jones | | U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| (If yes, give war or date of service) | | | | Jemima Baker - Dr. — | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | Address | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Acute Cardiac failure | | 1 day | | | |
| DUE TO | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | 2 years | | | |
| (b) Chronic Valvular heart disease | | | | | |
| (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION STATED IN PART I(a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month, Day, Year 19 | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (If applicable) | | 22b. DATE THEREOF 2/10/60 | | 22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Park, | |
| 22d. LOCATION (City, town, or county) Rockville, Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS ROCKVILLE, MD. | | 24a. REC'D BY REGISTRAR FEB 15 '60 | |
| Robert L. Saunders | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2290

CERTIFICATE OF DEATH

Reg. Dist. No.

02274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

| | | | | | | | |
|---|--|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Maryland</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | c. LENGTH OF STAY IN 1b <i>44 hrs.</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> | d. COUNTY <i>Maryland</i> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i> | d. STREET ADDRESS <i>1512 North Horner's Land</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>James Maryland Thompson</i> | First <i>J</i> | Middle <i>Maryland</i> | Last <i>Thompson</i> | 4. DATE OF DEATH Month <i>2</i> Day <i>22</i> Year <i>1960</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>November 30, 1884</i> | 9. AGE (In years last birthday) yrs. <i>75</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>James Andrew Thompson</i> | 14. MOTHER'S MAIDEN NAME <i>Emily Fox</i> | | Address <i>511 Sine</i> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>578-20-9573</i> | INFORMANT <i>Son Maurice Edward Thompson</i> | INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> | | DUE TO (b) <i>Myocardial hypertrophy/dilatation</i> | | DUE TO (c) <i>Hypertensive heart disease</i> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <i>2/20/60</i> , 19 <i>60</i> , to <i>2/22/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/21/60</i> , 19 <i>60</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above | | ADDRESS (Street, city or town, state) <i>Suite 900, 8218 Wisconsin Ave., Bethesda 14, Maryland</i> | | DATE SIGNED <i>2/23/60</i> | | | |
| ACTUAL SIGNATURE <i>Edward S. Witowski, Jr.</i> | | PHYSICIAN'S NAME (Type) <i>Edward S. Witowski, Jr.</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>2/25/60</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Forest Oak</i> | 22d. LOCATION (City, town, or county) <i>Gaithersburg, Md.</i> | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>TYSON WHEELER Funeral Home</i> | | ADDRESS <i>1531 E. Montg. Ave., Rockville, Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>FEB 25 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2291

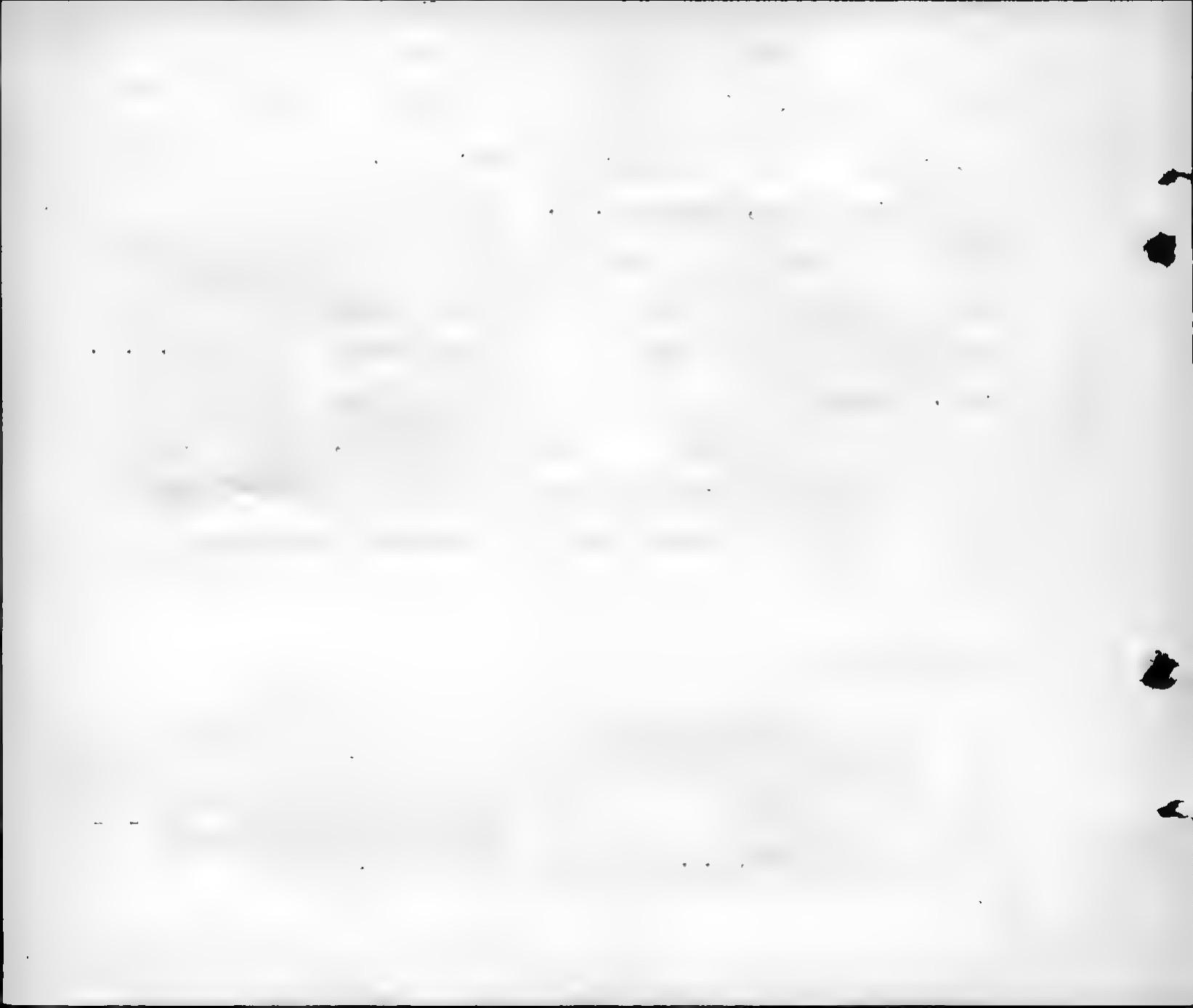
CERTIFICATE OF DEATH

Reg. Dist. No.

02273

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH o COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Florida b COUNTY | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c LENGTH OF STAY IN 1b 13 days | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Leslie | Middle Ann | Last Thompson |
| 4. DATE OF DEATH | Month February | Day 19 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 5, 1946 |
| 9. AGE (In years last birthday) yrs. 13 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student) | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Massachusetts | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Dan F. Thompson | 14. MOTHER'S MAIDEN NAME Geraldine Brown | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO None | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.2 Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Operative repair of Ventricular septal defect DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 30 hours | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from February 6, 1960 , to February 19, 1960 , that I last saw the deceased alive on February 19, 1960 , and that death occurred at 9:34 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town state) DATE SIGNED 2-20-60 | | | |
| ACTUAL SIGNATURE <i>Roland Folse</i> | M.D. | The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) Roland Folse, M.D. | 22d. LOCATION (City, town, or county) EAU GALLIE FLA. (State) | | |
| 22e. BURIAL, CREMATION OR REMOVAL (Specify) N/A | 22f. DATE THEREOF 2-23-60 | 22g. NAME OF CEMETERY OR CREMATORIUM | 24a. REC'D BY REGISTRAR DATE FEB 23 '60 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Kylee Funeral Home</i> | ADDRESS 816 11 St. NE Washington | 24b. REGISTRAR'S SIGNATURE C. L. & K. K. K. | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

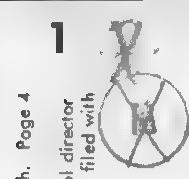
02275

2160 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|--|----------------------------------|--|--|--|--|--|-------------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Wash. D.C.</i> | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47x</i> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium and Hospital</i> | | d. STREET ADDRESS <i>1760 Euclid ST N.W.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Mrs. Edith Waugh Turnley</i> | | First | Middle | Last | 4. DATE OF DEATH <i>2 - 2 1960</i> | Month | Day | Year |
| S SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <i>12-21-04</i> | 9. AGE (In years last birthday) <i>55 yrs</i> | IF UNDER 1 YEAR Months <i>5</i> | IF UNDER 24 HRS Days <i>0</i> | Year Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | |
| 13. FATHER'S NAME <i>Albert Russell Doss</i> | | 14. MOTHER'S MAIDEN NAME <i>Lillian Bryant</i> | | INFORMANT <i>Edwin R. Turnley</i> | | Address <i>1760 Euclid at 265 (Son)</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>570.2</i> | | 16. SOCIAL SECURITY NO. <i>226-18-7269</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>7 DAYS</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>MESENTERIC THROMBOSIS</i> | | DUE TO (b) DUE TO (c) | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>EXTERIORIZATION OF CECUM 1/26/60; RESECTION JEJUNUM, LIVER PORTION ASCENDING COLON 2/1/60</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3:55 PM</i> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6727 16th St N.W.</i> | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <i>1/11</i> , 1960, to <i>2/2</i> , 1960, that I last saw the deceased alive on <i>2/2</i> , 1960, and that death occurred at <i>3:55 PM</i> , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) <i>WASHINGTON, D.C.</i> | | DATE SIGNED <i>2/2/60</i> | | |
| ACTUAL SIGNATURE <i>David Goldenberg</i> | | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>DAVID GOLDBERG</i> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>Feb. 4, 1960</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i> | | 22d. LOCATION (City, town or county) <i>Lynnhurst</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i> | | ADDRESS <i>300-4 1/2 St N.E. Wash. D.C.</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 4 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Cathleen E. Koenig</i> | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

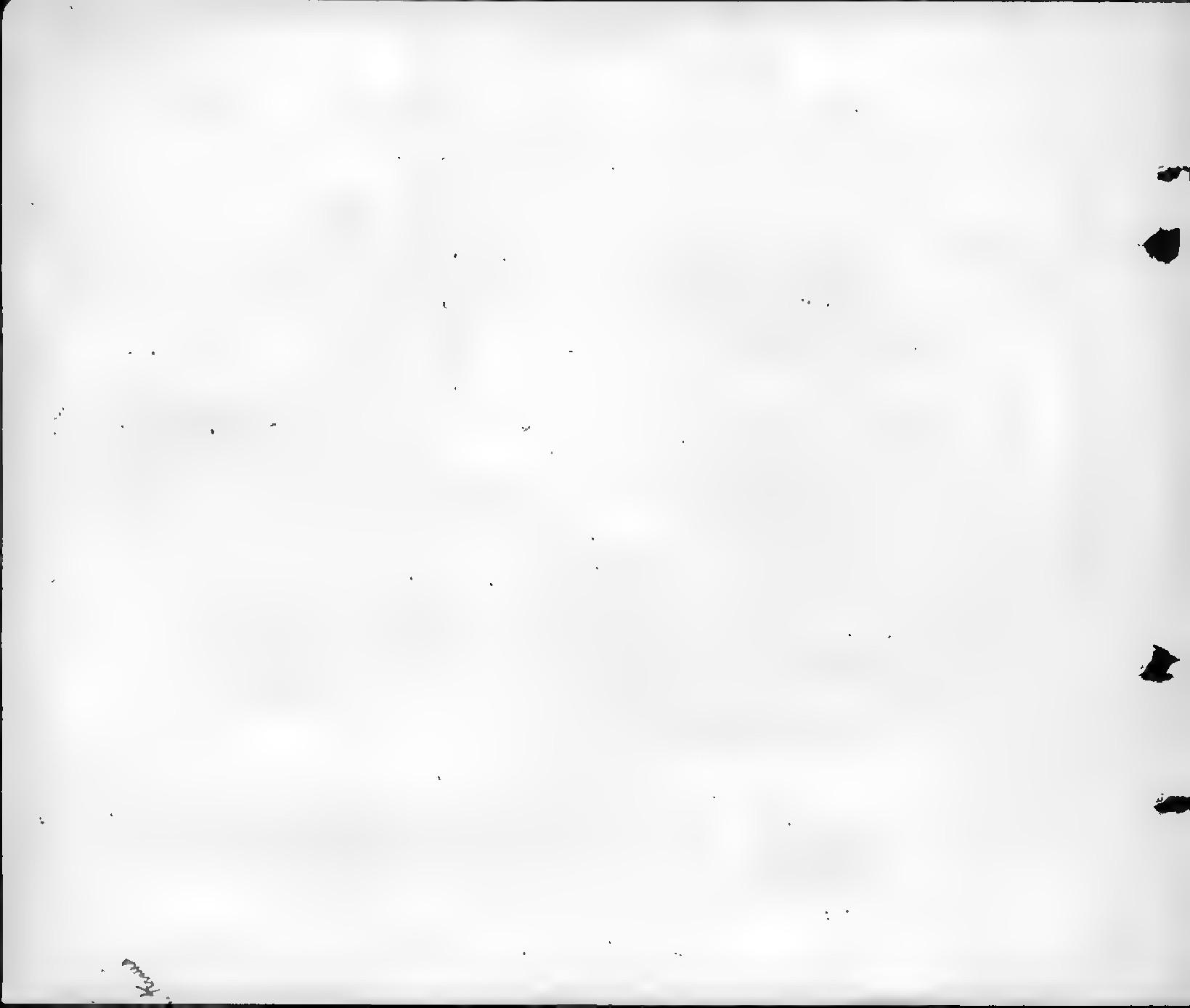
Item 9 File#GZ57 3-1-60 et

CERTIFICATE OF DEATH

Req. Dist. No.

02276

| | | | | | |
|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | |
| Montgomery | | | | a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Bethesda | | 1 day | | Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Suburban Hospital, | | 617 Stone Street | | | |
| 3. NAME OF DECEASED (Type or print) Catherine | | First Ida | Middle May | 4. DATE OF DEATH | Month Feb. Day 3 Year 19609 |
| 5. SEX female | | 6 COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH July 14, 1910 | 9. AGE (In years lost, birthday) 60 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) D.C. | |
| | | | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Green | | 14. MOTHER'S MAIDEN NAME Billie Windear | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | INFORMANT Sister - Helen L. Brunner Address South Haven Rockville | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic coma | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. } (b) Hyperglycemia and acidosis | | | | 24 hours | |
| { (c) Diabetes mellitus | | | | unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Tachobronchitis toxic nephrosis</u> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>W.Hall</u> DATE SIGNED <u>2/3/60</u> | | | | | |
| ACTUAL SIGNATURE <u>William Hall</u> | | M.D. <u>1511 Montgomery Ave Bethesda, MD 20816</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William Hall</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/7/60</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>St. Louis Park Cemetery</u> 22d. LOCATION (City, town, or county) <u>Rockville</u> (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Helen Schell</u> | | ADDRESS <u>Montgomery Ave Bethesda, MD</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Billie J. Tamm</u> | |



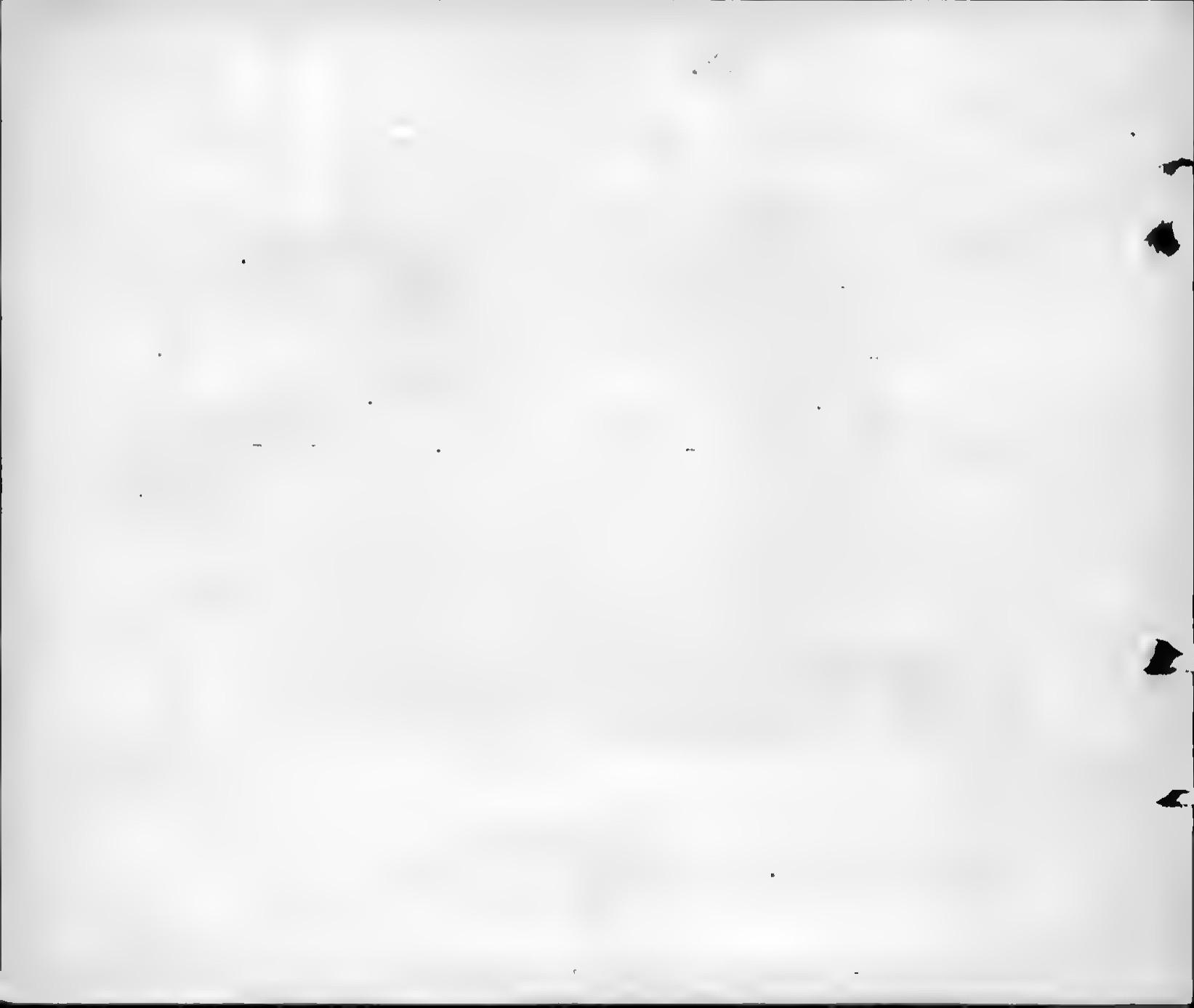
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2180 CERTIFICATE OF DEATH

Reg. Dist. No.

02277

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm is on) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. LENGTH OF STAY IN 1b 26 Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1945 Lewis Avenue | | d. STREET ADDRESS 1945 Lewis Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Richard | | First B | Middle Umstead, Sr |
| 4. DATE OF DEATH Feb. 28 | | Month Feb. | Day 28 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 4/29/98 | | 9. AGE (In years last birthday) 61 | 10. IF UNDER 1 YEAR Months 4 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | 11. BIRTHPLACE (State or foreign country) North Carolina |
| 12. CITIZEN OF WHAT COUNTRY? US. | | | |
| 13. FATHER'S NAME Ranier K. Umstead | | 14. MOTHER'S MAIDEN NAME Zula L. (Unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW 1 577-03-1338 | |
| 17. INFORMANT Richard B. Umstead-son-same as 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS INTERVAL BETWEEN DUE TO 420.1 ONSET AND DEATH 30 minutes Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CORONARY ARTERIOSCLEROSIS 15-YEARS DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) VIRAL GASTROENTERITIS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from FEB 27, 1960 to FEB 28, 1960 , that I last saw the deceased alive on FEB 28, 1960 , and that death occurred at 8:30P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gordon S. Rosenburger</i> M.D. ADDRESS (Street, city or town, state) 310 West Monty Ave. Rockville, MD DATE SIGNED 29 Feb 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/3/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National |
| 22d. LOCATION (City, town, or county) Arlington, Virginia | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | 24a. REC'D BY REGISTRAR DATE MAR 1 '60 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Friend | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

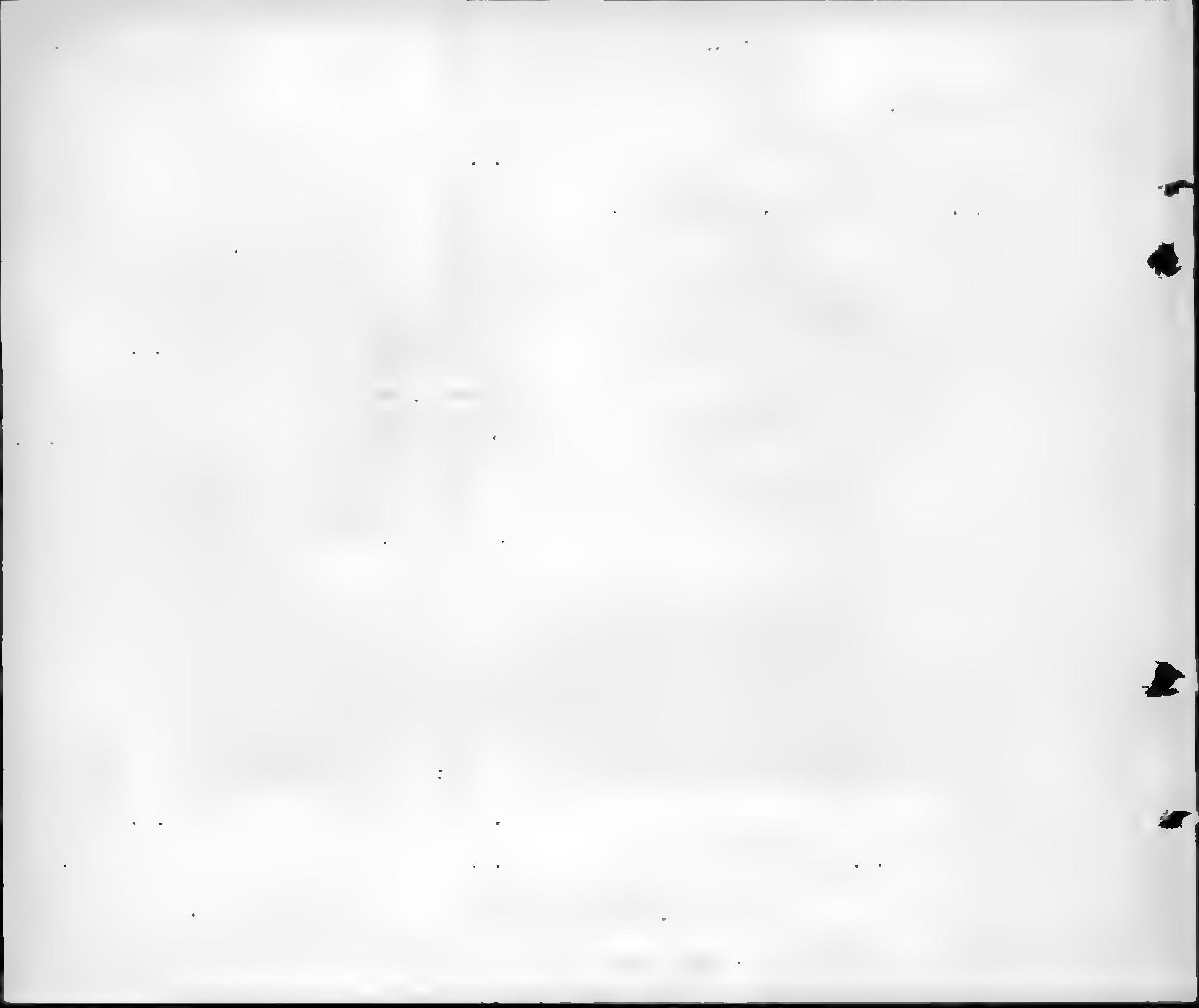
2293

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02278

| | | | | | | | |
|---|--|--|------------------------------------|--|--|---|---------------------|
| 1. PLACE OF DEATH o COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland | | b. COUNTY C+ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c LENGTH OF STAY IN lb 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Naval Station Hospital | | d. STREET ADDRESS Patuxent River Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Baby | Middle Girl | Last VIGIL | 4. DATE OF DEATH February 26 | Month Year 1960 | Day 26 | Year 1960 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2-25-60 | 9. AGE (In years last birthday) yrs 14 | IF UNDER 1 YEAR Months 14 | IF UNDER 24 HRS Hours 14 | Min 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Joe Vigil | | | | 14. MOTHER'S MAIDEN NAME Linda M. JOHNS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT Joe Vigil (Father) | | Address Hills Trailor Court, Lexington Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 560.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO peritonitis and bowel gangrene (b) DUE TO ruptured congenital omphalocele INTERVAL BETWEEN ONSET AND DEATH 12 hrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prima facie | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 25 February, 1960 to 26 February, 1960 , that I last saw the deceased alive on 26 February, 1960 , and that death occurred at 6:47A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 2-60 DATE SIGNED G.B. Avery | | | | | | | |
| ACTUAL SIGNATURE G.B. Avery | | | | | | | |
| PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md. | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/29/60 | 22c. NAME OF CEMETERY OR CREMATORIUM ST. ALOYSIUS CEMETERY | | 22d. LOCATION (City, town, or county) Leonardtown, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mattingley | ADDRESS Senwick St. Leonardtown Maryland | 24a. REC'D BY REGISTRAR DATE MAR 2 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thorne | | | |



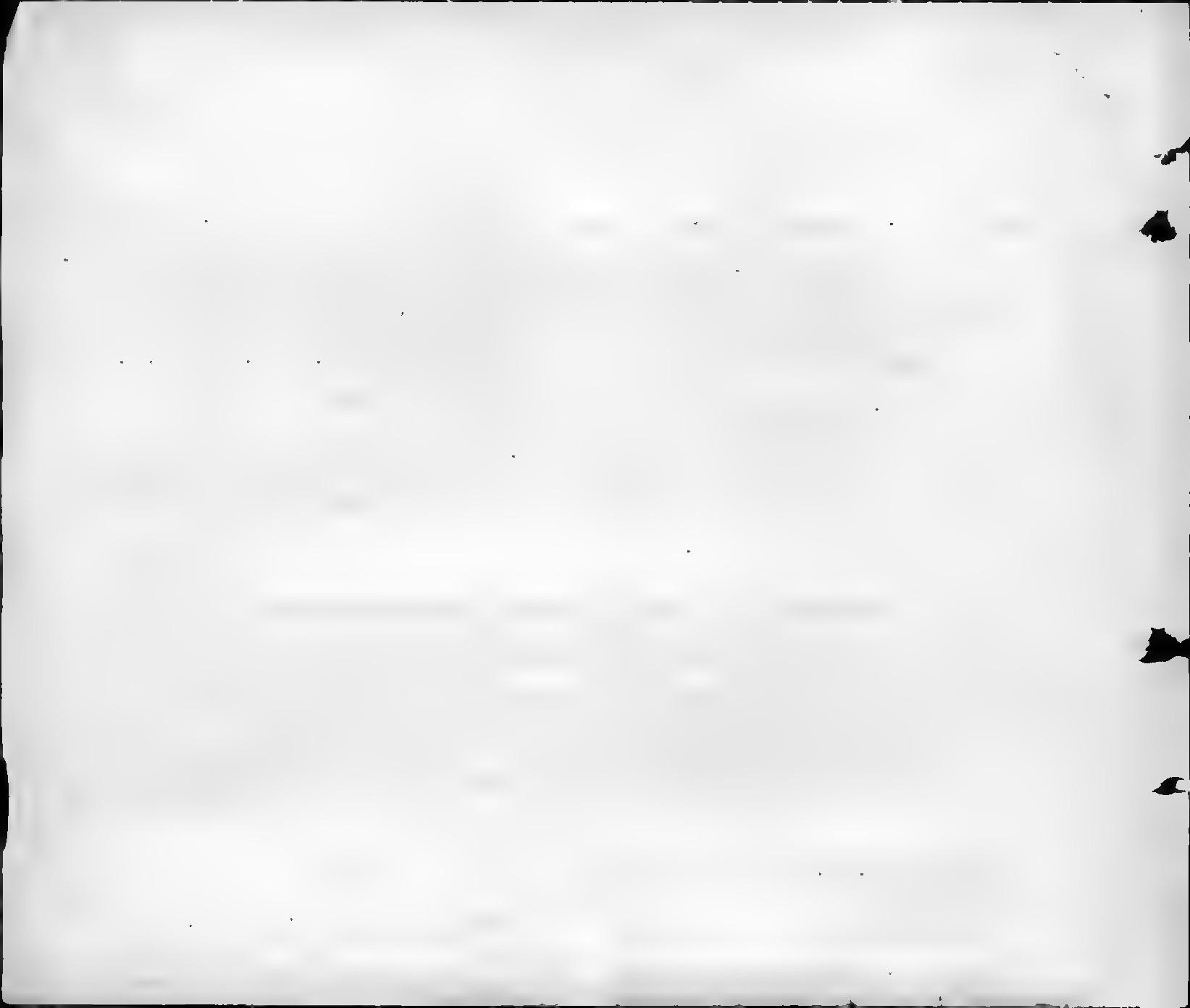
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2181 CERTIFICATE OF DEATH

02279

Reg. Dist. No.

| | | | | | | | | | | |
|---|----------------------------------|---|--|--|---|--|-------------------|-------------------------|-------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | c. LENGTH OF STAY IN 1b life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 E. Jefferson St., | | | | d. STREET ADDRESS 101 East Jefferson St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) NANNIE S. VINSON | | First | Middle | Last | 4 DATE OF DEATH February 12, 1960 | Month | Day | Year | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH August 18, 1868 | 9 AGE (In years last birthday) 91 yrs | 10 IF UNDER 1 YEAR Months 0 | Days 0 | Hours 0 | Min 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Montgomery Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME John T. Vinson | | 14. MOTHER'S MAIDEN NAME Rachael Prout | | Address Mrs. Albert Bouic, Rockville, Maryland | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Cerebral Hemorrhage - Right Hemisphere 8 days | | INTERVAL BETWEEN ONSET AND DEATH 5 years | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 33/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | Cerebral Hemorrhage - Right Hemisphere 8 days | | Astroclerosis | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 110 S. Washington St. | | 20f. (City or town) Rockville | | (County) M.D. | (State) Md. | |
| 21. I certify that I attended the deceased from 1928 , 19 Feb 12, 1960 , that I last saw the deceased alive on Jul. 11, 1960 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE H. A. Linthicum | | ADDRESS (Street, city or town, state) 110 S. Washington St. | | | | | | | DATE SIGNED 2/12/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/15/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) Washington, D.C. | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Rockville, Maryland | | ADDRESS Robert A. Pumphrey, Rockville, Maryland | | 24a. REC'D BY REGISTRAR Arthur S. Krause | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | | DATE FEB 16 '60 | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2294

02281

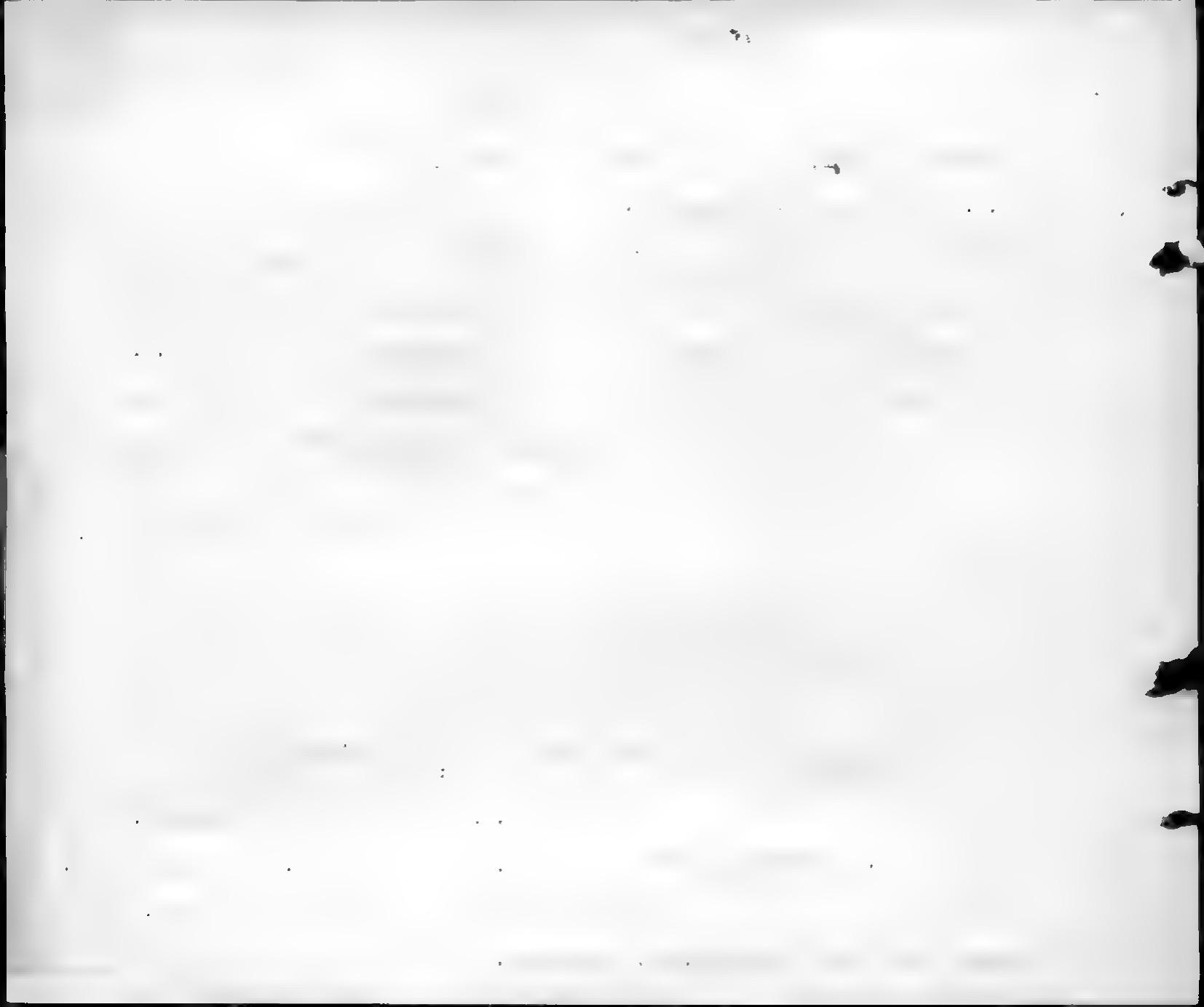
CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|-------------------------------------|--|-----------------------------------|--|--|---|--------------------------------------|-------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 97 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | d. STREET ADDRESS 7905 Chelton Road | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md. | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Ella | Middle Marie | Last WALKER | 4. DATE OF DEATH February 24 | Month February | Day 24 | Year 19 60 | |
| S SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 8-3-91 | 9. AGE (In years last birthday) 68 yrs | IF UNDER 1 YEAR Months 0 | Days 0 | IF UNDER 24 HRS Hours 0 | Min 0 |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME John ELLIS | | | | 14. MOTHER'S MAIDEN NAME Susan KELLY | | | | |
| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) | | INFORMANT (Daughter) Mildred SCHER | | Address Same as #2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.5 DUE TO Carcinoma rectae INTERVAL BETWEEN ONSET AND DEATH 6 M. | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma (c) 7 anus | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c TIME OF INJURY Hour o. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | 20f. (City or town) Philadelphia | (County) Penn. | (State) Penn. |
| 21. I certify that I attended the deceased from 19 November 1959 to 24 February 1960 , that I last saw the deceased alive on 24 February 1960 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 2-25-60 | | | | | | | | |
| ACTUAL SIGNATURE C.U.Bramlett | | | | | | | | |
| PHYSICIAN'S NAME (Type) C.U. BRAMLETT LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2-29-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Cemetery | | | 22d. LOCATION (City, town, or county) Philadelphia Penn. | | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Nally | | | | ADDRESS Nally 3200 Rhode Island Ave. Mt. Ranier, Md. | 24a. REC'D BY REGISTRAR FEB 29 '60 | 24b. REGISTRAR'S SIGNATURE Charles L. Krause | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12281

2130

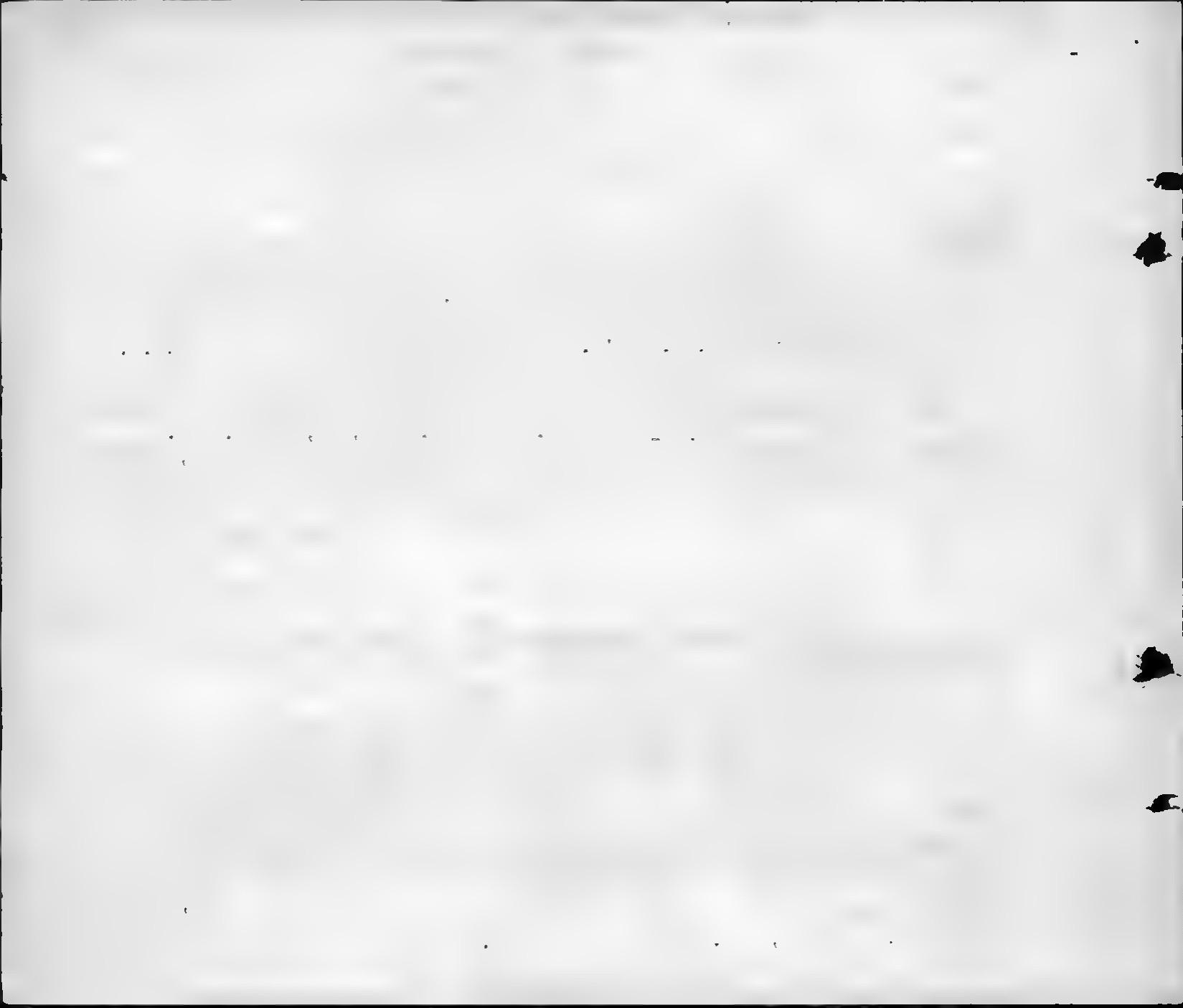
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 1 week | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3126 Helsel Drive | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| 3. NAME OF DECEASED (Type or print) FRANCES | | First MARY | Middle WALL |
| 4. DATE OF DEATH FEBRUARY 12 1960 | Month Month | Day Day | Year Year |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH June 16, 1897 |
| | | | 9. AGE (In years last birthday) 62 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't. | |
| 10c. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH FOLK | | 14. MOTHER'S MAIDEN NAME ELLA BROOM | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 210-12-1541 | |
| 17. INFORMANT Mr. Donald R. Wall, 13,304 Ga. Ave. | | Address Silver Spring, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | INTERVAL BETWEEN ONSET AND DEATH 12 HOURS | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO CARCINOMA OF BREAST WITH METASTASES 5 YEARS (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE CARDIAC DISEASE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1955 , to Feb 12 1960 , that I last saw the deceased alive on Feb 12 1960 , and that death occurred at 12 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7733 ALASKA AVE NW WASH 12 D.C. | | | |
| ACTUAL SIGNATURE <i>Robert L. Krichmar, M.D.</i> | | DATE SIGNED FEB 12 1960 | |
| PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR, M.D. | | | |
| 22a. BURIAL, CREMATION, OR REMAINS (Specify) BURIAL | | 22b. DATE THEREOF 2/15/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | 24a. REC'D BY REGISTRAR ADDRESS SILVER SPRING, MD. | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |
| | | DATE FEB 16 '60 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2295

CERTIFICATE OF DEATH

Reg. Dist. No.

12282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 15 Hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| 3. NAME OF DECEASED (Type or print) Virginia | | First M. | Middle Ward |
| 4. DATE OF DEATH Feb. 8 | | Month Feb. | Day 8 |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 2/12/80 | | 9. AGE (In years from birthday) 79 yrs. | 10. IF UNDER 1 YEAR Months 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Chestertown, Md. | 11. BIRTHPLACE (State or foreign country) U.S.A. |
| 13. FATHER'S NAME George E. Bennett | | 14. MOTHER'S MAIDEN NAME Florida Hackett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Same as Above Address Niece (Mrs. Katherine Sterling) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO cerebral hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterioscler. cerebral vascular disease DUE TO Hypertension cardiac arrhythmia | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 1959 to Feb 8 , 1960, that I last saw the deceased alive on Feb 7 , 1960, and that death occurred at 1633 M, from the causes and on the date stated above | | ADDRESS (Street, city or town, state) M.D. Chesapeake Hotel DATE SIGNED 2/8/60 | |
| ACTUAL SIGNATURE Robert Young | | PHYSICIAN'S NAME (Type) Robert Young | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 2-10-60 | 22c. NAME OF CEMETERY OR CREMATORIAL Chestertown Cem. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd | | 22d. LOCATION (City, town, or county) Chestertown, Md. | (State) |
| | | 24a. REC'D BY REGISTRAR FEB 10 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Trahan |
| | | DATE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2131

Item 8 FilmG256 2-18-50 et

CERTIFICATE OF DEATH

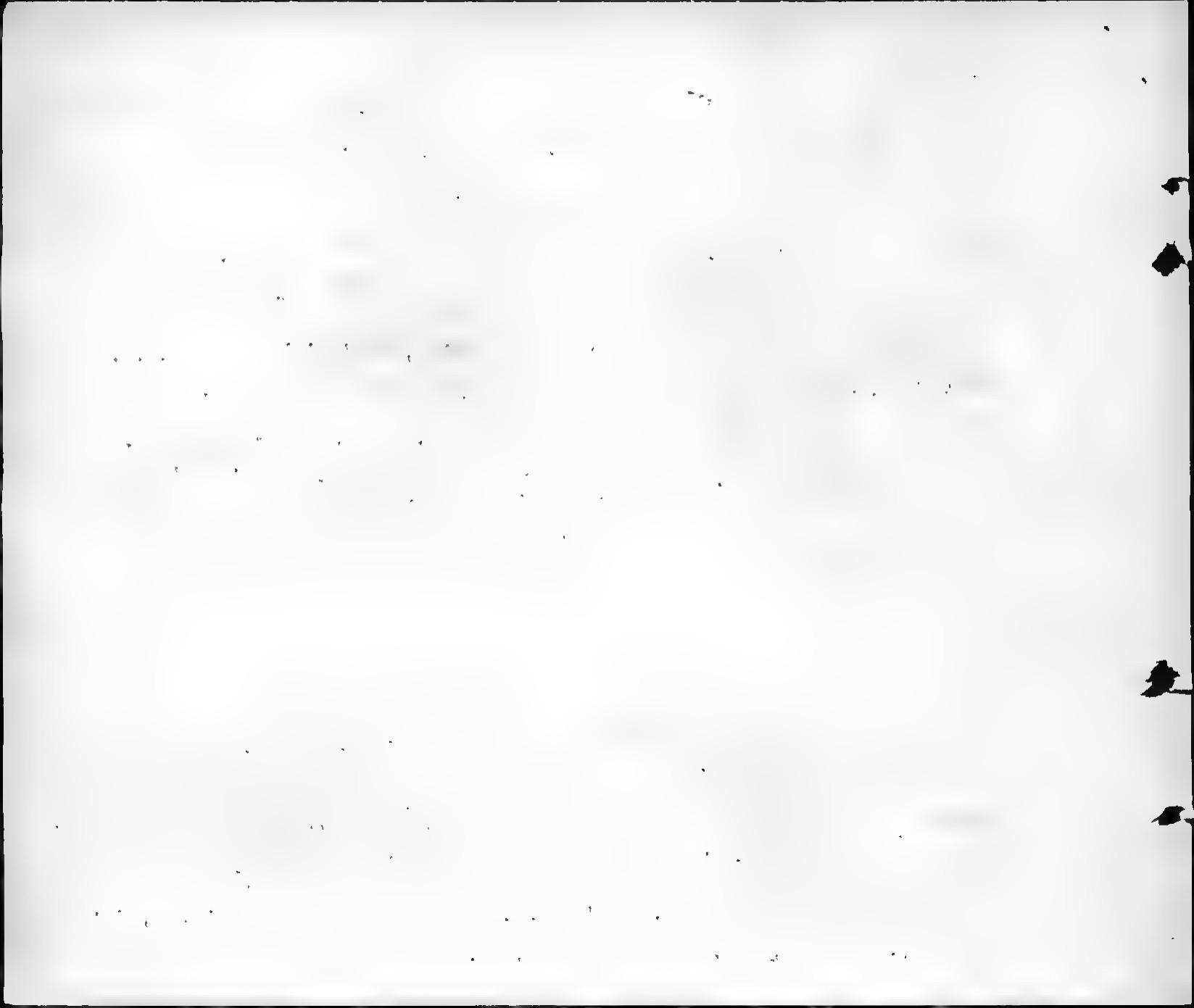
Reg. Dist. No.

02283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before adm'ns on) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b since 12/5/59 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7719 EASTERN AVENUE | | e. STREET ADDRESS 7719 EASTERN AVENUE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MARION MARTHA WATTS | | First | Middle |
| 4. DATE OF DEATH FEB. 5 1960 | Month | Day | Year |
| 5. SEX FEMALE | | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Nov. 8, 1869 | | AGE (In years (1st birthday) 90 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 9. PLACE OF BIRTH 172/14/92/69 | | 10. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY? X MARYLAND U.S.A. | |
| 13. FATHER'S NAME ODEON SKINNER | | 14. MOTHER'S MAIDEN NAME REBECCA M. GOODWIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO | | 16. SOCIAL SECURITY NO. INFORMANT Address | |
| | | Miss Alice C. Watts, 7719 Eastern Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO <i>Cardiac Decompenstation</i> | | Silver Spring, Maryland, between onset and death 4-5-72? | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cerebral edema</i> (c) | | ? | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1960 to 5 P.M. that I last saw the deceased alive on 4/7/60, and that death occurred at 5 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE WILLIAM D. AUD | | ADDRESS (Street, city or town, state) 906 Columbia Rd., Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 2/5/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/9/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CATH. CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. DUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | |
| | | 24a. REC'D BY REGISTRAR FEB 9 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Knard |
| | | DATE | |



FOR STATE
DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

2296

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

5 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

5006 Edgemere Lane

3. NAME OF
DECEASED
(Type or print)

Mary Rachael S. Webner

First Middle

4. SEX

Female white

6. COLOR OR RACE

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9-6-1867

9. AGE (In years
less birthday)

92 yrs

10. IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

13. FATHER'S NAME

William Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

McGraw

Address

W. Gordon Webner

Dec 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Congestive heart failure

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Hypertension

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

2-16-60

22a. FUNERAL CREMATION, 22b. DATE THEREOF
REMOVAL (Specify)

Cremation 2/16/60

22c. NAME OF CEMETERY OR CREMATORIAL

Lee's Crematory

22d. LOCATION (City, town, or country)

300-4th St. N.E. Wash. D.C. (State)

23. FUNERAL DIRECTOR

ADDRESS

J. William Lee's Sons Co. 300-4th St. N.E.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE FEB 18 '60

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2297

CERTIFICATE OF DEATH

Reg. Dist. No. 215

102285

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Virginia | | b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 24 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | d. STREET ADDRESS 1026 N. Madison Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | | | |
|--|-------|--------|------|------------------|-----------------|----------|-------------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Lost | 4. DATE OF DEATH | Month | Day | Year |
| | | | | WELSH | February | 3 | 1960 |

| | | | | | | | |
|-----------------------|--------------------------------------|---|-----------------------------------|--|--|--------------------------------------|--------------------|
| S. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2-3-60 | 9. AGE (In years lost birthday) yrs. 24 | IF UNDER 1 YEAR Months 24 | IF UNDER 24 HRS Days 24 | Hours 24 |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |

| | | | |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY - - - - - | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|--|--|--|

| | |
|---|---|
| 13. FATHER'S NAME John F. WELSH | 14. MOTHER'S MAIDEN NAME Margaret Ann VENEMAN |
|---|---|

| | | | |
|---|---|--------------------------------------|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) None | INFORMANT Hospital Records | Address |
|---|---|--------------------------------------|---------|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hydrops fetalis | | |
| 770.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Erythroblastosis fetalis | | |
| (c) DUE TO | | |
| (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

| | | | | | | | | |
|--|--|--|--|---|--|---|--|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|--|--|--|--|---|--|---|--|--|

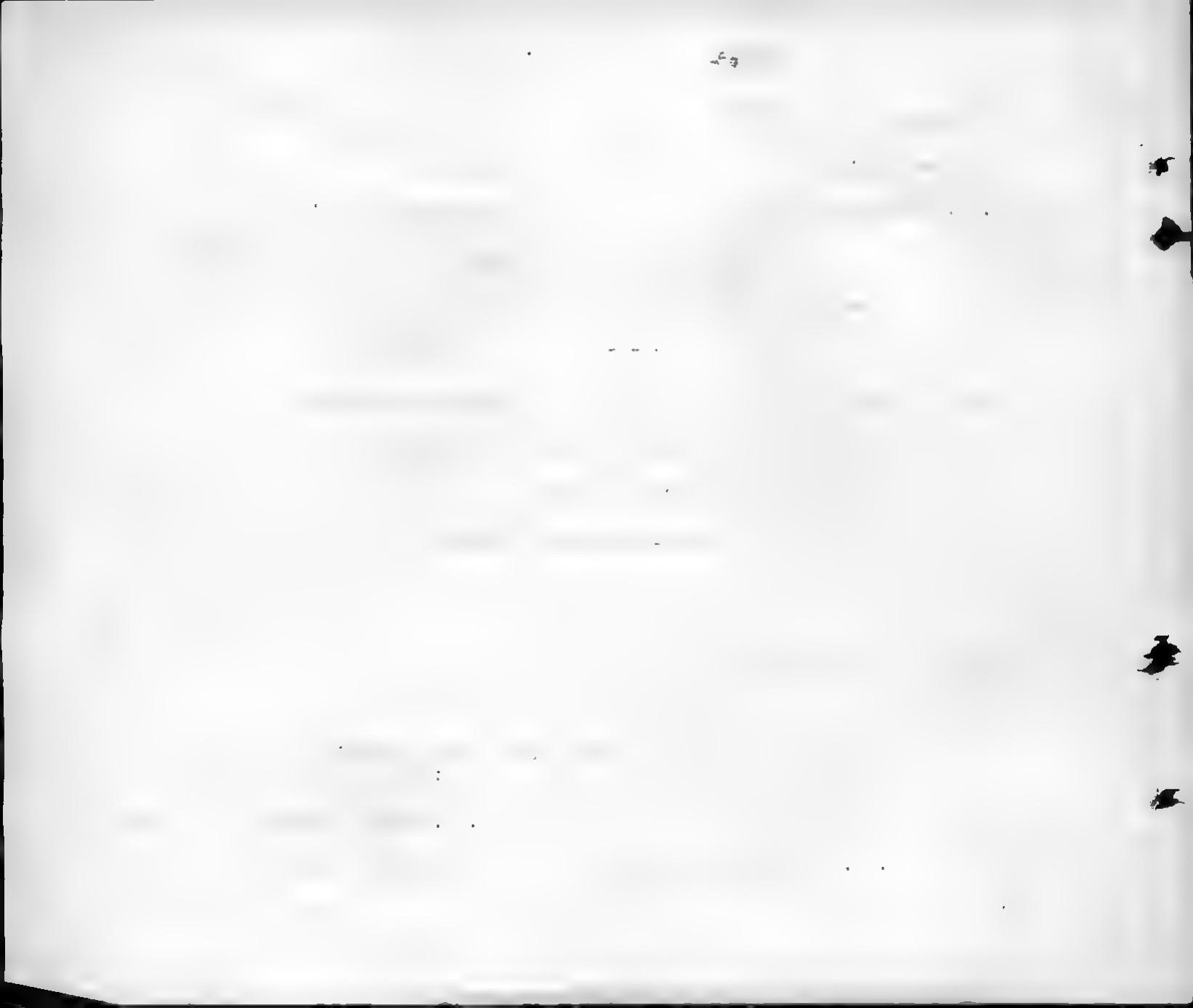
| | | | | | | | |
|--|--|--|--|--|--|---------------------------------------|------------------------------|
| 21. I certify that I attended the deceased from February 3, 1960 , to February 3, 1960 , that I last saw the deceased alive on February 3, 1960 , and that death occurred at 1:33 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | DATE SIGNED 2-4-60 |
|--|--|--|--|--|--|---------------------------------------|------------------------------|

| | |
|---|---------------------------|
| ACTUAL SIGNATURE <i>F. W. Grelio</i> | M.D. U. S. Naval Hospital |
|---|---------------------------|

| | |
|---|-----------------------|
| PHYSICIAN'S NAME (Type) F. W. GRELIO, LT, MC, USN | Bethesda 14, Maryland |
|---|-----------------------|

| | | | |
|--|------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/9/60 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington Virginia |
|--|------------------------------------|---|--|

| | | | |
|---|---------|---|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Seasons Funeral Home Falls Church VA</i> | ADDRESS | 24a. REC'D BY REGISTRAR DATE FEB 9 '60 | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i> |
|---|---------|---|---|



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2298

CERTIFICATE OF DEATH

Reg. Dist. No.

112286

| | | | | | | | |
|---|------------------|---|------------------|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c LENGTH OF STAY IN 1b Olney 27 days | | b. COUNTY | | Montgomery | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | X Olney | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| Montgomery County General Hosp. | | d. STREET ADDRESS 209 King William Drive | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle WILSON | Last WHITE | 4. DATE OF DEATH | Month 2. | Day 6 | Year 1960 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 73 yrs | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS Days | 12. IF UNDER 24 HRS Hours Min |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 6.9.1886 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Alexander White | | 14. MOTHER'S MAIDEN NAME Jenny S. Smiley | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 216-22-1400 | | INFORMANT | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Hodgkin's Disease</i> DUE TO <i>201X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug. 5, 1960</i> to <i>2-6-60</i> , 1960, and that death occurred at <i>2:15 p.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Jack Schumacher Gaithersburg Md. 2-6-60</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Jack Schumacher</i> | | PHYSICIAN'S NAME (Type) Dr. Jack Schumacher | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/8/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Darnestown Church Cem. | | 22d. LOCATION (City, town, or county) Darnestown, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home | | ADDRESS 1331 E. Montg. Rockville, Md. | | 24a. REC'D BY REGISTRAR FEB 9 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Traut | |

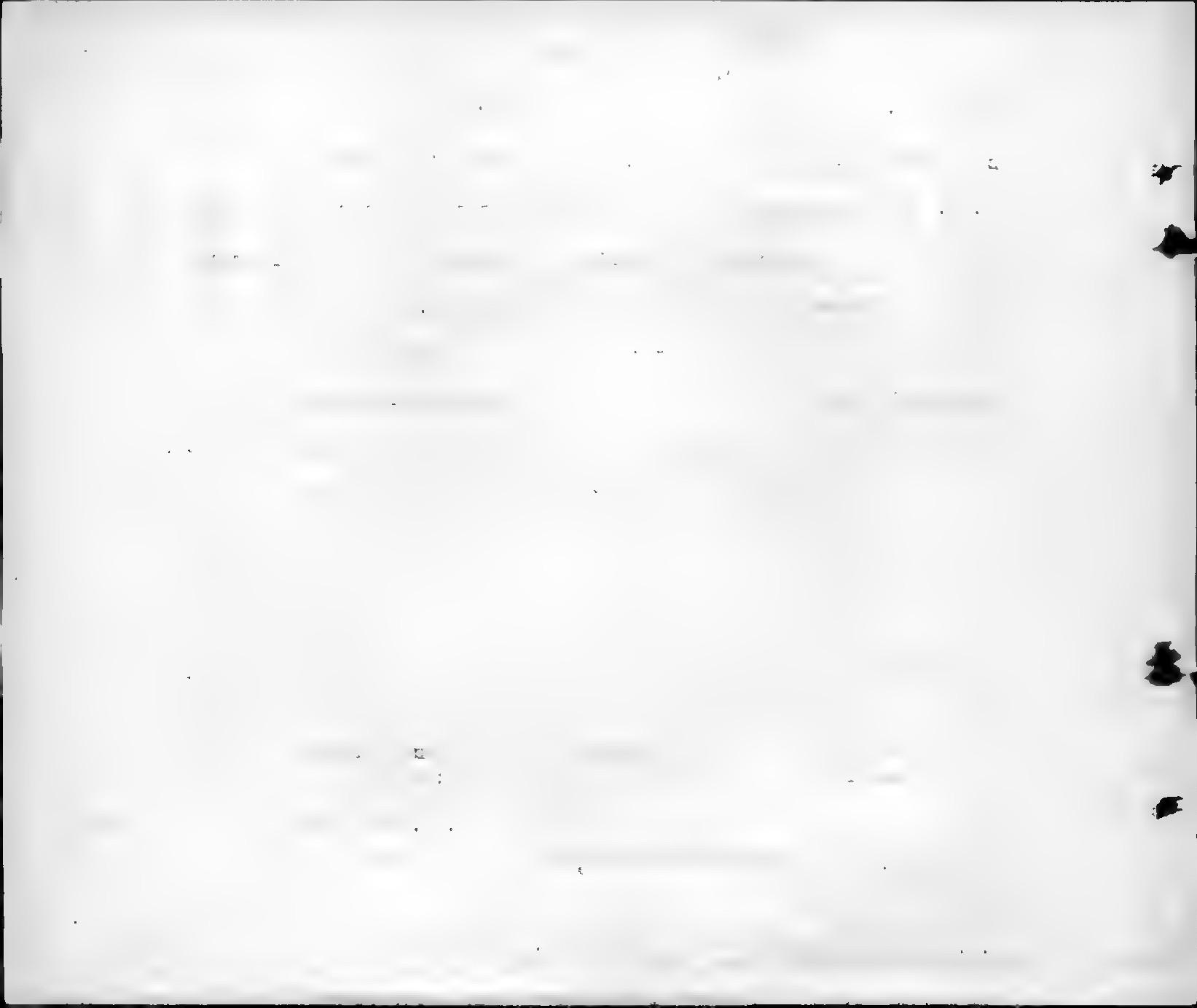


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2299 CERTIFICATE OF DEATH

112287

Reg. Dist. No. 215

| | | | | | |
|---|--------------------------------------|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH o COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE Maryland b COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c LENGTH OF STAY IN lb 3 days | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Town Creek Calif | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | d. STREET ADDRESS ----- | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Patricia | Middle Marie | Last WHITE | 4. DATE OF DEATH February 3 1960 | Month Day Year |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-12-53 | 9 AGE (In years last birthday) yrs. 6 | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John David WHITE | | 14. MOTHER'S MAIDEN NAME Lelia Marie GIBSON | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | INFORMANT (F) John D. White, same as #2 above | |
| 17. Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Transposition of Great Vessels) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) t.s. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) U. S. Naval Hospital (County) (State) | |
| 21. I certify that I attended the deceased from January 31, 1960 to February 3 1960 that I last saw the deceased alive on February 3, 1960 , and that death occurred at 4:43 P.M. from the causes and on the date stated above | | ADDRESS (Street, city or town, state) DATE SIGNED 2-4-60 | | | |
| ACTUAL SIGNATURE  | | M.D. U. S. Naval Hospital | | | |
| PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN | | Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-6-60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Monticello Memorial | |
| 22d. LOCATION (City, town, or county) Charlottesville | | (State) Va. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md. for Hill & Irving Funeral Home, Charlottesville, Va. | | ADDRESS Hill & Irving Funeral Home, Charlottesville, Va. | | 24a. REC'D BY REGISTRAR FEB 8 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Collier L. Friend | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2132 CERTIFICATE OF DEATH

02288

Reg. Dist. No

| | | | | |
|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b apprx. 12 yrs. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9026 FAIRVIEW ROAD | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | |
| 3. NAME OF DECEASED (Type or print) ELSIE (NMI) | | First WILLIAMSON | Middle Last | |
| 4. DATE OF DEATH FEBRUARY 14 | Month 1960 | Day | Year | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 2, 1868 | |
| 9. AGE (In years last birthday) 91 yrs | 10. IF UNDER 1 YEAR Months 1 | 11. IF UNDER 24 HRS Days 0 | 12. Hours 0 | |
| 13. FATHER'S NAME ROBERT WILLIAMSON | 14. MOTHER'S MAIDEN NAME REBECCA ELLIS | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. NONE | INFORMANT MRS. ESTHELENE MORGAN, 9026 FAIRVIEW RD., SILVER | Address SPRING, MD. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Pancreas Generalized Arteriosclerosis | | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) March 1, 1956, to Feb 14, 1960 | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 1, 1956, to Feb 14, 1960 that I last saw the deceased alive on Feb 14, 1960 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave | | | | |
| DATE SIGNED John J. Curry, M.D. 2/14/60 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 17, 1960 | 22c. NAME OF CEMETERY OR CREMATORY ZION HILL CEMETERY | 22d. LOCATION (City, town, or county) (State) TYLER COUNTY, WEST VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pritchett, Inc., Silver Spring, MD. | | 24a. ADDRESS Kaymond A. Ziska | 24b. REC'D BY REGISTRAR DATE FEB 16 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Traas |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02285

2161

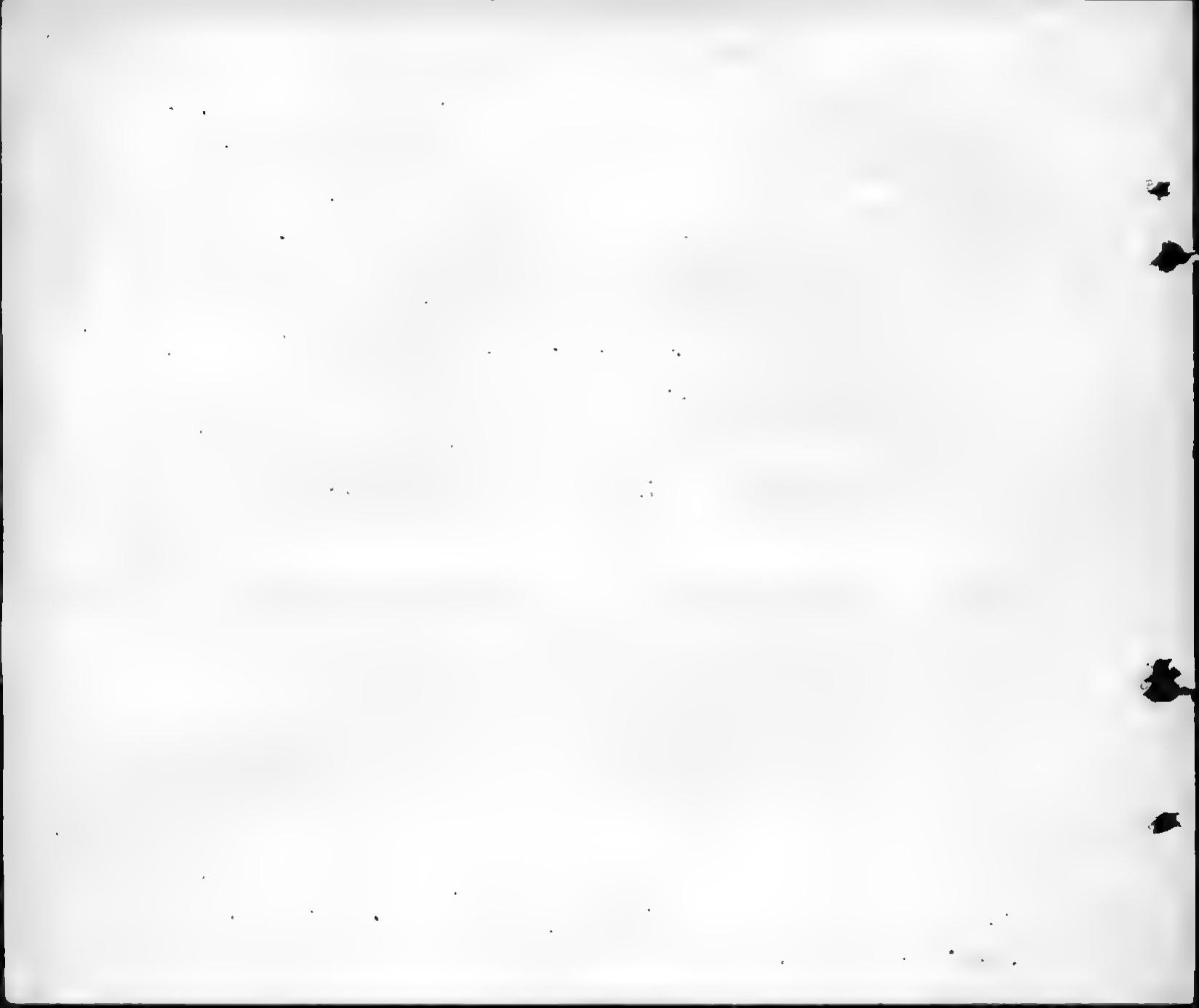
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|--|---|---|---|---|---|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. | | b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b WASHINGTAN SAN. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING. | | d. STREET ADDRESS 1021-QUEBEC TERR. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First IRVING | Middle - | Last WOLF | 4. DATE OF DEATH FEB - 7 - 1960 | Month FEB | Day 7 | Year 1960 |
| 5. SEX MALE | | 6. COLOR OF FACE Wh. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/6/1901 | | 9. AGE (In years last birthday) 58 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KEY | | 10b. KIND OF BUSINESS OR INDUSTRY GROCER | | 11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME BERNARD WOLKOVITCH | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 098-10-9296 | | INFORMANT LEAH WOLF 1021-Quebec TERR. SS# | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). | | 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Broadband Cesterna (c) Emphysema | | | | INTERVAL BETWEEN ONSET AND DEATH 1 7/11 | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Falls Church | (County) Falls Church | |
| 21. I certify that I attended the deceased from Feb. 1, 1960 to Feb. 7, 1960 , that I last saw the deceased alive on Feb. 6, 1960 , and that death occurred at 11 AM , from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) 1019 University Dr. Falls Church, Va. | DATE SIGNED 2/7/60 | |
| ACTUAL SIGNATURE Boris Robkin | | | | | | | | |
| PHYSICIAN'S NAME (Type) Boris Robkin | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATED | | 22b. DATE THEREOF 2/9/60 | | 22c. NAME OF CEMETERY OR CREMATORIUM Nat'l Mem Park | | 22d. LOCATION (City, town, or county) Falls Church, Va. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home | | ADDRESS 4217-927462 | | 24a. REC'D BY REGISTRAR DATE FEB. 9 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2162

CERTIFICATE OF DEATH

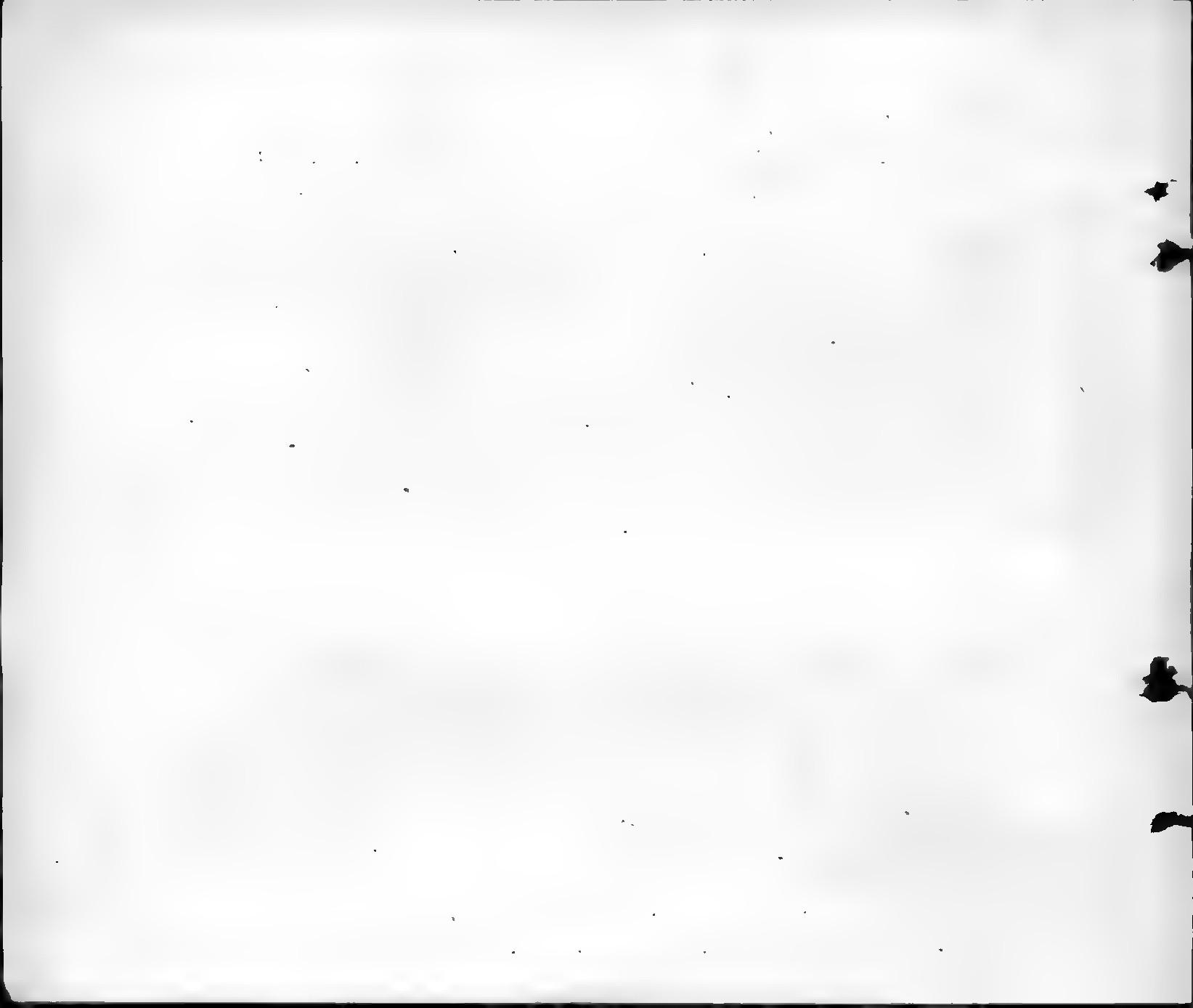
Reg. Dist. No.

112250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i> | | c. LENGTH OF STAY IN lb <i>1b</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SJH - ALBANY AVE</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i> | |
| 3. NAME OF DECEASED (Type or print) <i>JENNIE</i> | | d. STREET ADDRESS <i>632 JEFFERSON NW</i> | |
| First <i>JENNIE</i> | | Middle <i>-</i> | Last <i>WOLF</i> |
| 4. DATE OF DEATH <i>FEB - 16 - 1960</i> | | Month <i>FEB</i> | Day <i>16</i> |
| 5. SEX <i>FEMALE</i> | | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| | | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>2/15/1896</i> | | 9. AGE (In years last birthday) <i>76 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> |
| 10a. u.S.U.A. OCCUPATION (Give kind of work done during most affecting life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | 10c. BIRTHPLACE (State or foreign country) <i>RUSSIA</i> |
| 11. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>ELI HOROWITZ</i> | | 14. MOTHER'S MAIDEN NAME <i>RUTH LEE</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>578-20-0093</i> | |
| 17. INFORMANT <i>Louis Wolf</i> | | Address <i>632 Jefferson NW</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>420.0</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cardiac failure</i> | | | |
| (c) DUE TO <i>Art. Hypertensive Dis.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Dec. 1960</i> to <i>Feb. 1960</i> , that I last saw the deceased alive on <i>Feb. 16, 1960</i> , and that death occurred at <i>11:58 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Doris Schulman</i> | | ADDRESS (Street, city or town, state) <i>915-19th St. NW</i> | |
| PHYSICIAN'S NAME (Type) <i>ISIDORO SCHULMAN</i> | | DATE SIGNED <i>2-19-60</i> | |
| 22a. BUR. A., CREMAT. ON, REMOVED (Specify) <i>BURIAN</i> | | 22b. DATE THEREOF <i>2/18/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL <i>CHEV SHLOMO</i> | | 22d. LOCATION (City, town, or county) (State) <i>DC</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Isidoros Schulman</i> | | ADDRESS <i>Goldberg Funeral Home 4217 9th St NW</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>FEB 19 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i> | |



STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

MONTGOMERY

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]

2414 EVANS DRIVE

3. NAME OF
DECEASED
(Type or print)

RICHARD

5. SEX
MALE

6. COLOR OR RACE
WHITE

10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]
Repair man, Central office

10b. KIND OF BUSINESS OR INDUSTRY

C&P Telephone Co.

11. BIRTHPLACE [State or foreign country]

PENNA.

13. FATHER'S NAME

ADAM ELMER WOLF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give rank or date of service]

YES WW #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, II

19. WAS AUTOPSY PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Frank J. Broschart

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. BROSCART

ASSISTANT MEDICAL EXAMINER

M.D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

FEB. 29, 1960

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

TRANS. & BURIAL 3/2/60

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

YORK, PENNSYLVANIA

(State)

23. FUNERAL DIRECTOR

WARNER E. PUMPHREY INC.

ADDRESS

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

MAR 3 '60

DATE

24b. REGISTRAR'S SIGNATURE

Charles S. Trahan



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2163 CERTIFICATE OF DEATH

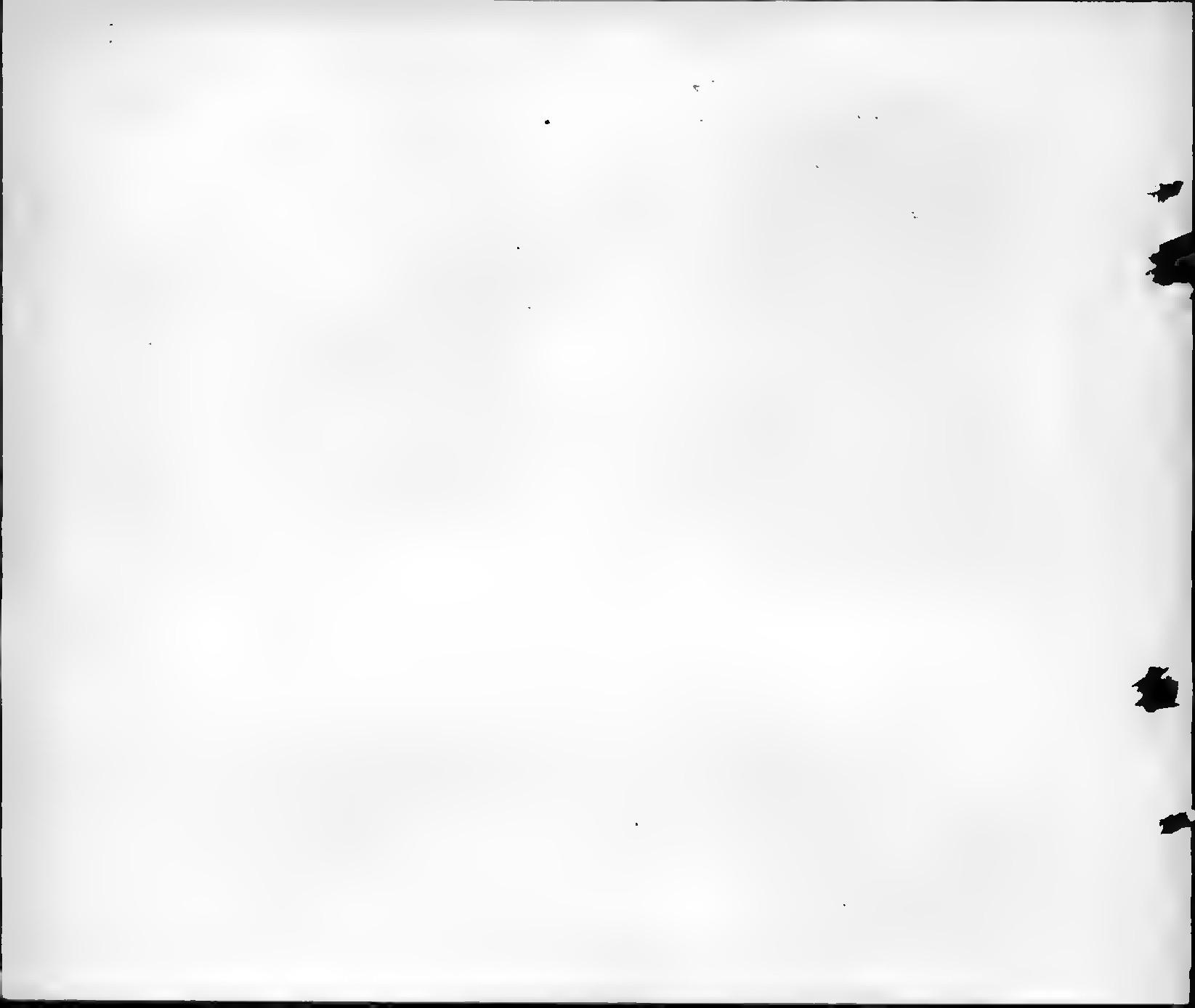
102292

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>1 day</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i> | | e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Sydney Lynette Wolman</i> | | 4. DATE OF DEATH <i>2 5 1960</i> | Month Day Year |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Cauc.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>12-13-59</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| 10c. BIRTHPLACE (State or Foreign, country) <i>Maryland (Baltimore - USA)</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>-</i> | |
| 13. FATHER'S NAME <i>Benjamin R. Wolman</i> | | 14. MOTHER'S MAIDEN NAME <i>Jeanne H. Laurentz</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. INFORMANT <i>Father - same as above</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>49IX</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a) <i>(b)</i> | | | |
| DUE TO cause (c), stating the underlying cause lost. <i>(c)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congenital Heart Disease. Type. - bldet.</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>-</i> |
| 21. I certify that I attended the deceased from <i>12/13</i> , 19 <i>58</i> to <i>2/15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/15</i> , 19 <i>60</i> , and that death occurred at <i>Baltimore Hebrew</i> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ralph Stiller</i> | | ADDRESS (Street, city or town, state) <i>931 Ashby Drive- md.</i> | |
| PHYSICIAN'S NAME (Type) <i>Ralph Stiller</i> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 22b. DATE THEREOF <i>2-7-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i> |
| 22d. LOCATION (City, town, or county) <i>Baltimore Md</i> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Ottaway Place</i> | | 24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> |



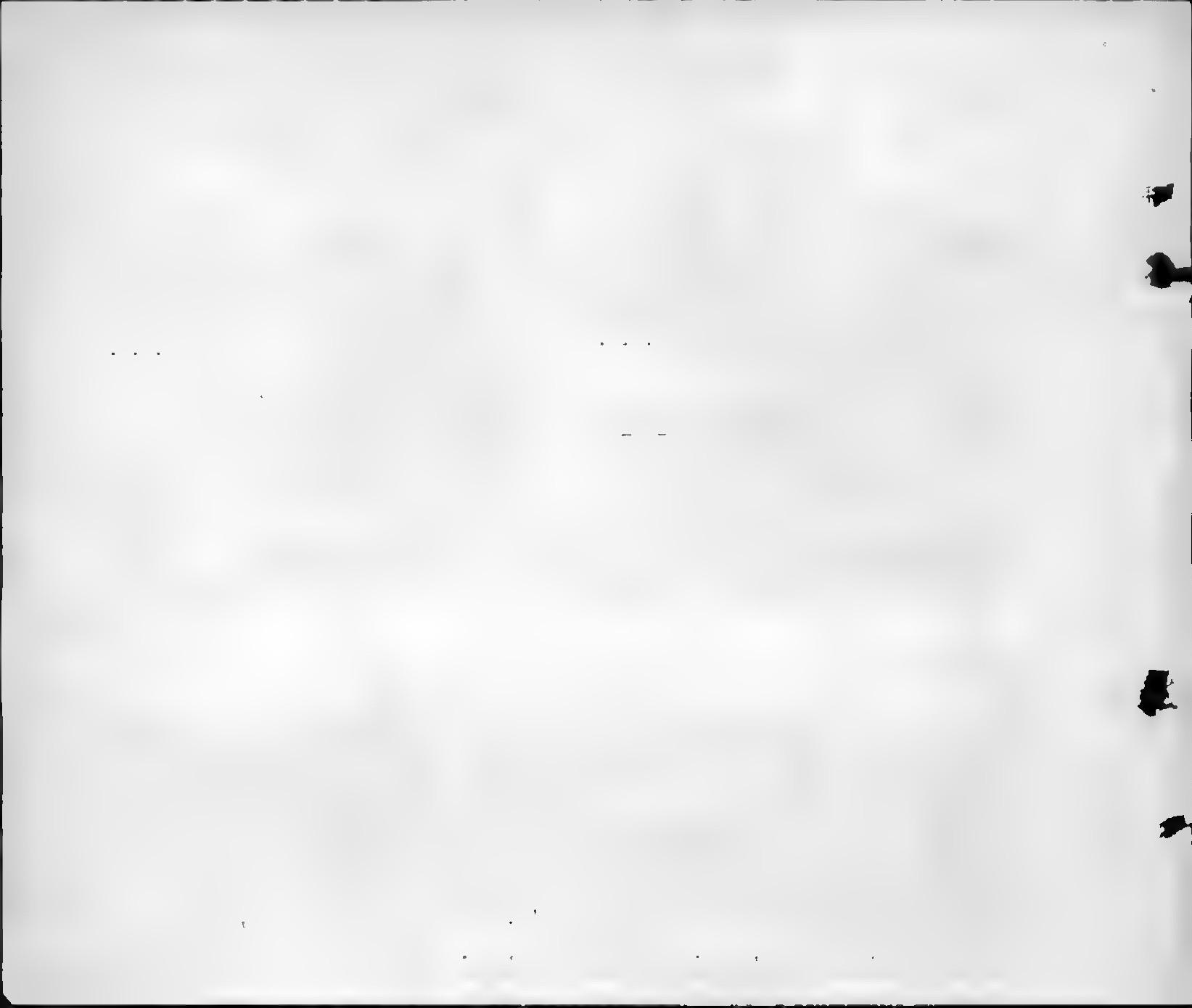
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02293**

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK. | | c. LENGTH OF STAY IN TB. 25 Hours 15 Min | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital | | e. STREET ADDRESS 3410 Embry St. | |
| 3. NAME OF DECEASED (Type or print) MARION | | First Roselle | Middle Woodring |
| 4. DATE OF DEATH Feb. 11 1960 | | Month | Day |
| 5. SEX Female | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| | | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, if any, & if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY N.I.H. | |
| Housewife | | 11. BIRTHPLACE (State or foreign country) Minn. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Sonheim | |
| 14. MOTHER'S MAIDEN NAME Ida CORNELIA Weeks | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 469-07-0354 | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock | | 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) 1st 2nd + 3rd degree burns from scalding | |
| | | DUE TO 2/3 of body + extremities | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned at home due to house fire | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 - 10 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) Wheaton (County) Montgomery (State) MD | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | DATE SIGNED 2-11-60 | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) FRANK J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/15/60 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L. CEMETERY | | 22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR FEB 15 '60 |
| | | | 24b. REGISTRAR'S SIGNATURE John S. Haas |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 113. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2300

CERTIFICATE OF DEATH

Reg. Dist. No.

02294

| | | | | | | | | |
|---|--|---|---|--|---|--|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>MARYLAND</u> | | b. COUNTY <u>MONTGOMERY</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN lb <u>11 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA MD</u> | | d. STREET ADDRESS <u>6216 GREENTREE Rd.</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> | | First | Middle <u>H.</u> | Last <u>WRIGHT</u> | 4. DATE OF DEATH <u>1-2-1884</u> | Month <u>1</u> | Day <u>2</u> | Year <u>1960</u> |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-2-1884</u> | 9. AGE (In years last birthday) <u>76 yrs.</u> | IF UNDER 1 YEAR Months <u>76 yrs.</u> | IF UNDER 24 HRS Days <u>Hours</u> | <u>Min</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL DYE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>DAVID HENRY WRIGHT</u> | | | | 14. MOTHER'S MAIDEN NAME <u>TEN BROECK</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>183-103-6593A</u> | | INFORMANT <u>MRS. H. A. McCRAH</u> | | Address <u>6216 GREENTREE Rd. BETHESDA, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hours</u> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> 5 YRS | | | | | | | | |
| (c) DUE TO <u>ARTERIOSCLEROSIS GENERALIZED</u> 5 YRS | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>M.D. 5009 Del Ray Ave., Bethesda, Md.</u> | | (County) | | (State) |
| 21. I certify that I attended the deceased from <u>Nov. 17</u> , 1959, to <u>Feb. 8</u> , 1960, that I last saw the deceased alive on <u>Feb. 7</u> , 1960, and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <u>Robert G. Angle</u> ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>2/8/60</u> | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u> | | 5009 Del Ray Ave. Bethesda, Md. | | | | | | |
| 22a. BUR. A. CREMATION; REMOVAL <input type="checkbox"/> <u>Bur-Transit</u> | | 22b. DATE THEREOF <u>2/10/60</u> | | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Holy Sepulchre Cem.</u> | | 22d. LOCATION (City, town or county) <u>Philadelphia, Penna.</u> (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02295

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i> | | b. COUNTY <i>MONTGOMERY</i> | |
| c. LENGTH OF STAY IN lb <i>21 yrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 SILVER SPRING</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2023 LANIER DRIVE</i> | | d. STREET ADDRESS <i>2023 LANIER DRIVE</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>ABBIE</i> | | First <i>G.</i> | Middle <i>YOCUM</i> |
| 4. DATE OF DEATH <i>Feb. 25, 1960</i> | | Month <i>Feb.</i> | Day <i>25</i> |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <i>JAN. 22, 1877</i> | | 9. AGE (In years lost birthday) <i>83 yrs.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOMEMAKER (retired)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>SHAMOKIN, PENNSYLVANIA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>LYBRAND HUFMAN</i> | | 14. MOTHER'S MAIDEN NAME <i>ISABEL POWELL</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | |
| 17. INFORMANT <i>Mrs. Cora Y. Duhn, 2023 Lanier Dr.</i> | | Address <i>Silver Spring, Maryland</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33 IX</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | <i>Cerebral Hemorrhage</i> <i>Arterio-sclerosis</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Feb. 20, 1960</i> to <i>Feb. 25, 1960</i> , that I last saw the deceased alive on <i>Feb. 25, 1960</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>6911 5th St. NW Wash. 12, DC.</i> | |
| ACTUAL SIGNATURE <i>A. B. Little</i> | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <i>A. B. LITTLE, MD</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>2/27/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIUM <i>FOREST OAK CEMETERY</i> | | 22d. LOCATION (City, town, or county) (State) <i>GAITHERSBURG, MARYLAND</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Humphrey, INC.</i> | | 24a. REC'D BY REGISTRAR DATE <i>Feb 29 '60</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>James. Knob</i> | |

RECEIVED IN THE LIBRARY OF THE UNIVERSITY OF TORONTO

CERTIFICATE OF DEBT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2301 CERTIFICATE OF DEATH

Reg. Dist. No. 012296

| | | | |
|---|-------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNT Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland | c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | d. STREET ADDRESS 9108 Louis Avenue |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home | | e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LEO xxxxxx | First Zwißler | Middle low | 4. DATE OF DEATH Month February Day 6, Year 1960 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 13, 1874 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Potomac Elec. | 11. BIRTHPLACE (State or foreign country) Kentucky |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. AGE (In years last birthday) yrs. 85 months 5 hours 23 min. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Johanna O-Dekoon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. - - - - Yes | 17. INFORMANT Daughter Mrs. Geo. Goetzman- Chevy Chase, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>Generalized Arteriosclerosis</i> | |
| 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO <i>Diabetes Mellitus</i> | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Dec. 18, 1959, to Feb. 6, 1960, that I last saw the deceased alive on Jan. 14, 1960, and that death occurred at 7:50 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 1019 University Boulevard, Silver Spring, Maryland DATE SIGNED 12/6/60 | |
| ACTUAL SIGNATURE Boris Robkin | | M.D. | |
| PHYSICIAN'S NAME (Type) Boris RASKIN | | 22d. LOCATION (City, town, or county) Suitland, Maryland (State) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-9-60 | 22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | 24a. REC'D BY REGISTRAR FEB 9 '60 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krause | |

